

# Achievement of Therapeutic Objectives

Therapeutic Process and Theory of Change in  
Affect Phobia Therapy within a  
Single-case Observational Design

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# Abstract

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Title: Achievement of Therapeutic Objectives. Therapeutic process and theory of change in Affect Phobia Therapy within a single-case observational design.

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**Objective:** This study investigates the therapeutic process of one person receiving forty sessions of Affect Phobia Therapy (APT; McCullough, 1997). APT postulates systematic desensitization of affect phobia to be essential for affect restructuring, leading to therapeutic healing. The four process variables hypothesized to be essential in this process were examined and include; Insight, Motivation, Activating affects and Inhibiting affects. Change in process variables were analyzed between-sessions across the course of therapy, and potential sequential relationships between the variables were analyzed within-sessions. **Method:** The data analyzed was from a Randomized Controlled Trial of brief Cognitive Therapy and APT (Svartberg et al. 2004). The participant was diagnosed with Cluster C personality disorder and assigned to the APT condition. Outcome assessments consisted of SCL-90-R, IIP-127 and MCMI-III. The outcome data at treatment termination indicated some symptom reduction, but suboptimal therapeutic effects regarding personality-and interpersonal problems. Two-year follow-up showed significant change on all outcome measures. All videotaped sessions were observed and rated on a quantitative process measure, the Achievement of Therapeutic Objectives Scale (ATOS; McCullough et al., 2003). Between-session analyses were conducted using linear regression models. Within-session analyses were performed using ARIMA time series models. Additional qualitative descriptions were included to illustrate the basis of ATOS scorings and used for discussing the therapeutic process and the proposed theory of change. **Results:** The predicted increase in Insight, Motivation and Activating affect, and decrease in Inhibiting affects across therapy were not confirmed in this study. Neither were the predicted within-session temporal relationships between the process variables found. Only one temporal relationship between the process variables was found and indicated that Insight in one segment predicted Activating affect in the next. **Conclusion:** The suboptimal change rated on the process variables was indicative of a less than optimal therapy course. These findings may illuminate the patient's outcome scores at treatment termination. The outcome at two-year follow-up could not be readily predicted by the ATOS process-scores, but may be understood in light of other theories of therapeutic change.

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# 1 Introduction

It has been well documented that psychotherapy brings about positive effects in psychological health (Ablon, Levy & Katzenstein, 2006; Bergin & Lambert, 1978; Garfield, Prager & Bergin, 1971) and there are now numerous meta-analyses confirming that treatment versus no treatment produces rather strong effects (e.g. Smith & Glass, 1980). Research suggests that a wide variety of psychotherapies are effective but the specific curative ingredients have been hard to document (Ahn & Wampold et al., 2001; Wampold et al., 1997).

Psychotherapy researchers have demanded methods that can shed light on what actually accounts for change (e.g. Kazdin, 2005). Recent psychotherapy research has witnessed an increasing interest in the intensive study of individual cases (e.g. Busse, Kratochwill & Elliot, 1995; Elliot, 2010; Hillard, 1993). E.g. Stiles (2007) argues that various forms of case studies offer an important supplement to group-level statistical hypothesis testing in illuminating established theories, and as a base to refine, extend, elaborate, modify and qualify theory. The principle strength of these methods is that they can provide evidence for the theories that underlie effective practice of psychotherapy, as they add detailed information and context to the course of therapy by following the process closely with multiple observations.

The present study closely examines the therapeutic process of one person, diagnosed with Cluster C personality disorder, receiving Affect Phobia Therapy for forty sessions (APT; McCullough et al., 2003). The therapeutic process is laboriously monitored by the use of a quantitative observer-rated assessment instrument, the Achievement of Therapeutic Objectives Scale (ATOS; McCullough et al. 2004). The ATOS assesses change in a number of objectives proposed to be central in psychological treatment. A main focus is on affects'<sup>1</sup> and affective activation's centrality in the change process. The quantitative measures are supplemented by qualitative descriptions adding general information about the psychotherapeutic process to the ATOS-ratings. The aim of this study is to illuminate the processes and effects of what McCullough et al. (2003) have termed affective restructuring, a dimension of change proposed to be central for psychotherapeutic success and psychological well-being after psychotherapy.

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<sup>1</sup> Because of inconsistent labeling in the literature (e.g. Cole, Martin and Dennis, 2004), the concepts emotion, affect and feeling will be used interchangeably in this text.

## **1.1 Affect-focus in psychotherapy**

Emotional distress is usually what brings people to therapy (Whelton, 2004) and the study of emotions is one of the fastest growing study-areas in psychology (Cacioppo et al. 2007). The growing interest in affects can be seen in light of the increasing neuroscientific and general psychological literature on the principal role of emotions in mental processes (LeDoux, 2000), decision making (Redelmeier, Rozin & Khaneman, 1993) and social relations (Stern, 1999), physiological and psychological functioning (Stanton et al. 2000).

From birth onward, emotions seem to constitute a primary signalling system that communicates intentions and regulates social interaction (Sroufe, Carlson, Levy & Egeland, 1999). Several connections between emotional development and adaptive and maladaptive behavior has been empirically documented (Izard, 2002). The study of emotional intelligence, defined as the ability to perceive, use, understand and manage emotions, and the association with success in important domains such as personal and work relationships, and psychological well-being, has gained accumulating evidence (Salovey & Grewal, 2005). The ability to experience and express feelings is associated with congruent communication and positive close relationships (Mongrain & Vettese, 2003). Conflict over emotional expression has been linked to social and marital dissatisfaction and reduced well-being (Emmons & Colby, 1995).

The importance of experiencing and expressing feelings has also been related to physiological functioning and somatic health (Dienstbier, 1989). Positive correlations between suppressing emotional reactions and psychological and physiological stress symptoms such as autonomic arousal have been found (Wastell, 2002). This relationship is important, because chronic autonomic activation has been linked to lowered immune functioning and psychosomatic illness (Pennebaker & Beall, 1986). Emotional processing has been postulated as a central therapeutic aspect of recovery from a variety of illnesses and ailments, e.g. by predicting adjustment to breast-cancer (Stanton et al. 2000). The ability to flexibly regulate emotions has also been found to predict long-term adjustment with lowered distress after stressful events (Bonanno, Papa, Lalande, Wetphal & Coifman, 2004).

All personality disorders and more than half of the non-substance abuse Axis I disorders have been found to involve some form of emotional dysregulation (Gross & Levenson, 1997).

Getting it right about feelings is therefore seen as being of fundamental importance for the individual's psychological, social, and physical health and well-being.

The focus on emotions in psychotherapy is not a new one and emotions have been central to a number of established schools of psychotherapy (e.g. Bowlby, 1980; Kohut, 1977; Rogers, 1951; Perls, 1969). A revitalized interest in emotions as specific targets for change in psychotherapy has however developed in the last decades (e.g. Greenberg, 1998; Monsen, Eilertsen, Melgård & Ødegård, 1996). Affect and emotional processes in therapy have been studied across different therapy modalities and received support as a central feature of change in experiential–humanistic therapy (Greenberg, 2008), psychodynamic therapy (Davanloo, 1978; Kernberg, 1992; Monsen et al, 1996), interpersonal therapy (Watson, 1996), cognitive therapy (Samilov & Goldfried, 2000; Strosal, Hayes, Bergan & Romano, 1998; Teasdale, 1993) and behavior therapy (Foa & Kozak, 1986).

Despite the growing consensus of the importance of emotions, the literature points to divergent effects of the patients' affective reactions in therapy (Orlinsky, Rønnestad & Willutzki, 2004). Review of ten published studies and a meta-analysis investigating overall level of affective arousal in therapy indicated a positive correlation to outcome in fifty percent of the studies. However, it was not associated with negative outcomes. Studies of positive affectivity (e.g. joy or interest) in therapy have found consistent associations to positive outcome, while review–studies of patients' distress and negative affectivity (e.g. shame, anger, sadness) in therapy present a mixed and unclear picture with positive, neutral and negative correlations to outcome (ibid).

Some of the contradictory findings in the field may be due to the often–used general categorization of affects, into positive or negative. This categorization might be misleading as all affects probably have evolved through their beneficial effects for human adaptivity, and thus can be “positive” if used in accordance with their natural adaptive properties (Darwin, 1899; Izard, 1991) (e.g. cry when sad, flee in fear when endangered etc). Furthermore, it would seem that all affects could be “negative” or maladaptive, if their natural response tendency is misused or blocked (McCullough, 1997). E.g., Greenberg (2008) stresses the importance of distinguishing among different emotions with different functions, i.e. adaptive or maladaptive, and thus intervening differently with different types of emotional processes.



## 1.2 Affect Phobia Therapy (APT)

APT is a short-term dynamic psychotherapy (STDP) developed on the basis of a psychotherapeutic tradition spanning over more than 50 years of clinical work and research, and is inspired mainly by the work of Davanloo, Malan and Sifneos (as cited in McCullough et al., 2003). The most central departure in APT from earlier STDP-models is that defensive behavior is more often clarified than confronted, and anxiety therefore is primarily regulated rather than provoked (McCullough, 1997).

There is accumulating empirical support for the STDP-models effect in treating Axis I and Axis II disorders. A number of meta-analyses demonstrate overall efficacy of STDP models in samples of various mental disorders (Abbass, Hancock, Henderson & Kissely, 2006; Anderson & Lambert 1995; Leichsenring, Rabung & Leibing, 2004). In treatment of personality disorders, STDPs have shown reduction in symptoms and personality disorder criteria compared to waiting list controls (Vinnars, Barber, Noren, Gallup & Weinryb, 2005; Winston et al., 1994). Hellerstein et al. (1998) found significant improvement at termination and six months follow-up of STDP in a population of Cluster C patients. Another study of Cluster C patients showed statistically significant improvement in symptoms and interpersonal problems after forty sessions of STDP and at two years follow-up (Svartberg, Stiles & Seltzer, 2004).

APT stresses the need to treat emotional disorders with a focus on the affects' function in the person's life and learning history. A main differentiation is made: affects that evoke opening, approaching or energizing, are called "activating affects" (i.e. anger/assertion, sadness/grief, enjoyment/joy, interest/excitement, closeness/tenderness, sexual desire, positive feelings for self and fear). Affects that function by inhibiting action, restraining energy and motivates avoidance or withdrawal, are termed "inhibitory affects" (i.e. anxiety/panic, guilt, shame/humiliation, contempt/disgust and pain/anguish). Both activating and inhibiting affects can be adaptive and maladaptive depending on the way they are integrated and balanced in accordance with the context and experience of the individual (McCullough et al., 2003). E.g. anger used adaptively gives relief and resolution, but aggression and acting out may be defined as defensive and can escalate a negative situation and make things worse. Anxiety signals the need to protect the self, but can also be blocking and paralyzing to adaptive responses in maladaptive versions.

The theory leans on the assumption that the patient's experience and expression of activating affect have lead to aversive outcome and is therefore associated with inhibitory affect, resulting in "affect phobia". According to the theory surrounding Affect Phobia Therapy (APT) developed by Leigh McCullough et al. (2003), many Axis I and II disorders can be conceptualized as results of phobic reactions to internal affective stimuli. A central point in this therapy is that fears or conflicts about feelings, affect phobias, are the causative agents of "neurotic pathology". Affect phobias are thought of as learned responses to one's emotional life, which means that the responses can be unlearned and replaced by more adaptive responses in therapy. These conflicts and phobias center around not only sex and aggression, as classic Freudian theory would suggest, but around any of the fundamental human affects. In clinical practice, the patient's problems can often be understood as rooted in one or more affect phobias, which leads them into the difficulties they experience. For example, patients who are afraid of expressing anger or asserting themselves, might feel numb, withdraw and act compliantly in a situation that calls for anger and assertion. Patients phobic of closeness, can devalue the other person or put on a "tough front", act rejecting and isolate themselves etc. Patients afraid of feeling and expressing grief may choke back tears, distract themselves and behave unaffected. There are unlimited ways of avoiding affective experience and affect expression. What they have in common is a postulated fear of affects or affect phobia.

### **1.2.1 Conceptualization of psychological structure: Defenses and the "Triangle of conflict"**

Defenses, first described by Sigmund Freud (1894/1964), are mental mechanisms which defend against unpleasant impulses/instincts, anxiety etc. (Vaillant, 1992). It is postulated that it is common for all forms of defenses that they regulate emotions, are relatively unconscious, and that they repress, deny or distort reality in some form or another. In behavioral-terms defenses represent avoidance-behavior that allows the patient to escape the intra-psychic conflict about feelings. Defensive behavior can be manifested through behavioral, cognitive or emotional mechanisms (McCullough, 1997). Increased level of adaptive defensive functioning has been linked to symptomatic change in long-term follow up studies of psychodynamic therapy for individuals with personality disorders (Bond and Perry, 2004).

APT conceptualizes psychology and psychopathology in line with Malan's (1979) "Triangle of Conflict". The triangle of conflict is derived from Freudian structural theory (1923) where impulses and true feelings are blocked by defensive behavior driven by anxiety (inhibiting feelings). The triangle of conflict describes three poles where impulses (activating affect), anxiety (inhibiting affect) and defense represent each pole. Theoretically, people are thought to need some adaptive defenses, and inhibitory feelings are important to modulate activating feelings adaptively. When the triangle is in balance, there is a normal and flexible interaction of activating affects, inhibiting affects and defenses. Interventions and treatment are needed when the poles are out of balance and rigid. In APT, defenses are seen as "compromise responses" that reduces the level of struggle between activating and inhibitory affects. According to APT, symptoms are understood as defenses against conflicting affects and can be thought of as "the best way the patient knew how to cope in the past" (McCullough, 1997, p 24). Early ways of coping with and handling the developmental environment may later in life develop into maladaptive, rigid and pathological resolution-strategies that need restructuring. The triangle is a "working model" that guides and focuses the therapeutic work in APT.

### **1.2.2 Processes and mechanisms of change**

The aim of APT is to teach patients to use affects in a more adaptive way. Adaptive use of affect has been described as "the ability to integrate and balance emotions in accordance with the context and experience of the individual" (McCullough et al., 2003, p 31). The core focus in APT is restructuring of emotional responses, which means changing the structure of an affect phobia. This is what occurs when adaptive affect is no longer associated with punishment (anxiety, shame, guilt, pain), but rather associated with positive consequences (e.g. validation, support, empathy, collaboration and building compassion for the self). The main mechanism of change in APT is restructuring of maladaptive defenses and gradual desensitization of feared affect (Barlow, 1988) in order to free up more adaptive emotional responses. The process is hypothesized to work through the principle of corrective emotional experience (Alexander and French, 1946) in which old, unresolved affect phobias are re-experienced, but resulting in positive rather than negative consequences and outcome.

For this purpose, McCullough (1997) has developed two broad therapeutic objectives<sup>2</sup>. The objectives are:

- The restructuring of defenses, consisting of a) gaining insight, i.e. making the patient aware of the defensive/maladaptive behavior and b) building motivation, i.e. making the defensive/maladaptive behavior undesirable and promote willingness to change.
- The restructuring of affect, consisting of a) exposure of the phobic activating affects, and b) continual regulation of inhibitory affects.

The objectives of restructuring of defenses and restructuring of affect can be differentiated into four hypothetical and presumably essential process variables in therapy: Insight, Motivation, Activating affect and Inhibiting affect. These four process variables are reviewed and discussed in the following section and their significance and status in psychotherapy theory and research is delineated.

### **1.2.3 The four process variables**

#### **Insight**

The capacity and willingness to self-examine and achieve personal insight is one of the exceptional aspects of human functioning (Messer & McWilliams, 2007). Self-understanding has also been viewed as a protective agent against mental illness as far back as the age of antiquity (Castonguay & Hill, 2007). Psychotherapy has been described as a systematic method for healing through self-understanding (Frank & Frank, 1991). Yet, despite its assumed importance in therapeutic work, there has been relatively limited empirical research into the role of insight in therapy (Johansson & Høglend, 2007).

Particularly psychoanalytic—and psychodynamic orientations hypothesize that insight into unconscious material is a curative ingredient in treatment (Messer & McWilliams, 2007). Insight has also been proposed as a beneficial common factor in therapy, cutting across different forms of therapy, and has been proposed as present and critical to all therapeutic orientations in that it involves obtaining a functional understanding of one's problem,

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<sup>2</sup> APT also defines a third therapeutic objective, Self- and Other- restructuring. The main focus of the model, however, is on the first two objectives, and accordingly the present study restricts itself to examining them.

complaint, or disorder through the process of psychotherapy (Wampold, Imel, Bhati & Johnson–Jennings, 2007). E.g., Ablon and Jones (1999) found insight to be correlated with outcome in both CBT and interpersonal therapy. Grosse, Castonguay, Boswell, Wilson and Kakouros et al. (2007) found that insight occurred in CBT, but to a lesser degree than in dynamic and interpersonal therapy. Connolly Gibbons, et al. (2009) found insight to be a key ingredient and associated with outcome in psychodynamic therapy, but not in CBT. Thus, insight seems to be one potential mechanisms of change, especially in psychodynamic therapy.

Still, a meta- analysis by Connolly Gibbons, Crits-Christoph, Barber and Schamberger (2007) which investigated insight in therapy, using the terms insight or self-understanding found mixed results when testing the hypothesis that more insightful patients fare better in psychotherapy. Only four of the eight examined studies found a positive relationship between insight gained through therapy and favorable outcome. The remaining four studies did not indicate such relationship. All in all, challenges associated with varying measures, definitions, diagnostic groups, types of treatment and treatment length seem to complicate the understanding of the role of insight in the therapeutic process (Kallestad et al., 2010).

The divergent findings may in some ways be due to different operationalizations of the concept. Insight is not a simple phenomenon and several attempts have been made to nuance the concept, for example by distinguishing between intellectual and emotional insight (Gelso & Harbin, 2007). Emotional insight is suggested as the most effective kind of insight, as it connects central affects and thoughts presumed to be the source of the patient's symptoms. Theorists have also underlined the importance of insights associated with emotional processing (Greenberg & Malcom, 2002) and affective arousal (Pennebaker & Seagal, 1999) for healing. Other theorists point to the role of insight as a means to facilitate emotional restructuring and some studies indicate that insight enables emotional elaboration (e.g. Milbrath et al. 1999).

In an attempt to integrate and propose an acceptable consensus for defining the concept of insight, Hill et al. (2007) have suggested that insight should be understood as a “conscious meaning shift involving new connections” (pp. 442). This definition underlines a sense of newness and connections, entailing that the patient connects past with present, therapist with other or cognition with affect to name a few. In APT, insight is seen as a mediator of behavioral change and is the first step in defense restructuring, usually termed defense

recognition (McCullough et al., 2003). When conceptualizing defenses as basically unconscious responses patients use to avoid conflicted affects, insight is the first step in making exposure and response prevention possible. Also distinguishing the origin of defensive patterns from their maintaining factors is a way of preparing the patient for change (McCullough, 1997).

The study of insight in this study is based on videotape analysis of therapy sessions rated on the Achievement of Therapeutic Objectives Scale (ATOS: McCullough et al. 2004). The ATOS defines Insight as “level and awareness of maladaptive patterns” including 1) degree of clarity and completeness of verbal descriptions of maladaptive patterns of thoughts, feelings and/or behaviors, with explicit examples and 2) degree of ability to state why and how maladaptive/defensive patterns began and are maintained.

## **Motivation**

The second process variable related to defense restructuring is motivation. It has long been recognized that the patient’s motivation is a pivotal factor in psychological treatment (e.g. Chamberlain, Patterson, Reid, Kavanagh & Forgatch, 1984; Davanloo, 1978; Derisley & Reynolds, 2000; Malan, 1979; O’Malley, Shu & Strupp 1983; Pelletier, Tuson, & Haddad, 1997; Prochaska & Prochaska, 1999; Schneider & Klauer, 2001; Siegel & Fink, 1962). For instance, lack of motivation has been identified as one of the most frequently cited reasons for dropout, relapse, failure to comply and other negative treatment outcomes (Ryan, Plant, & O’Malley, 1995).

Despite the vast interest in treatment motivation and its assumed role in the therapeutic process, reviews have shown that motivation for therapy was related to outcome in only 50% of the studies (Orlinsky, Grawe & Parks, 1994). The divergent findings on the role of motivation in treatment may be seen in light of the ambiguity of the concept and the many different definitions and measures that have been used (Drieschner, Lammers & van der Staak, 2004). Illustrating the great variety in terms related to motivation, Rosenbaum and Horowitz (1983) collected 125 terms and definitions that they considered pertinent to treatment motivation. Most definitions have one thing in common, they describe motivation as an internal force that “moves” an organism in a particular direction (Drieschner et al., 2004). Drieschner et al (2004) notes that some of the confusion about the concept, relates to the fact that it is usually not specified *what* behavior the motivation is connected to.

They argue that there is a distinction between treatment motivation, which encompasses motivation to enter treatment and staying in treatment, and motivation to change which applies to well-defined problematic behavior.

Another aspect of motivation is the patient's level of suffering, which has been held up as a pivotal determinant of treatment motivation (eg. Sifneos, 1980; Long, Williams, Midgley & Hollin, 2000; Miller, 1985; Raskin, 1961).

The psychotherapeutic process is a working process where the patient not only receives treatment, but must actively participate and take motivated steps to change. Meta-analyses of client-related process variables associated with, and partly overlapping with the concept of motivation, have shown to be of paramount importance to outcome (e.g., clients suitability for treatment, role engagement, openness versus defensiveness) (Orlinsky et al., 2004).

The term motivation as it is used in this article is defined by the ATOS as the level of desire the patient has to give up maladaptive patterns and includes: 1) motivation to give up maladaptive patterns of thoughts, feelings, and/or behaviors and 2) the degree of dislike, undesirability or sorrow specifically about the costs of defenses or maladaptive behavior. The definition of motivation specifically focuses on defensive behavior related to specific affect phobias, and includes the patient's level of suffering as an indicator of motivation.

### **Activating and Inhibiting affects**

In reviewing the literature on emotions Cole, Martin and Dennis (2004) conclude that there is no single agreed upon definition of affect, but that there is a general consensus that affect is a multidimensional phenomenon, including "biologically prepared capabilities evolved and endured in humans because of their extraordinary value for survival" (p.319). This can be seen as a continuation of Darwin's (1899) and William James' (1884) theory, which states that emotions are response tendencies stemming from significant evolutionary situations. These response tendencies can, in James' view, be either approach motivated or withdrawal motivated, depending on what is beneficial in the situation (Gross & Levenson, 1997). Damasio's (1994) demonstration that humans without emotional capacity after brain lesions lack the ability to make motivated choices and commit goal-directed activity lends validity to the role of emotions as response tendencies. The finding that an adaptive response can be either an expression or an inhibition of affect responses illustrates how different emotions

guide and motivate us and on what grounds our emotions are grouped together. Furthermore, that affects “are a kind of radar and rapid response system, constructing and carrying meaning across the flow of experience. Thus, emotions are the tools by which we appraise experience and prepare to act on situations” (Cole et al., 2004, p. 319).

As before mentioned, the importance of accessing and working with affective experience in psychotherapy has been noted by several psychotherapy researchers and has been noted as central to psychological treatment (e.g. Burum, Goldfried & Brook, 2007; Greenberg, 2008; Monsen et al, 1996; Teasdale, 1993). There are also studies indicating a positive relationship between in-session arousal and exposure to avoided feelings in treatments for anxiety (Mineka & Thomas, 1999; Suveg, Southam-Gerow, Goodman and Kendall, 2007), depression (Hayes & Strauss, 1998; Castonguay, Goldfried, Wiser, Raue & Hayes, 1996) and trauma (Pennebaker & Seagal, 1999). Furthermore, exposure to avoided feelings has been proposed as at least one of the general active ingredients or mechanisms of change in psychotherapy (Greenberg & Pascual-Leone, 2006). Outcome studies on emotional arousal have, as previously mentioned, received mixed results, whereas positive affects seem to have a positive relationship to outcome. Distressing and negative emotions in sessions have “strong effects that can be for good or ill depending on how effectively the therapists deal with them” (Orlinsky et al., 2004, p.345). This review does however separate emotions into positive or negative valence, not on the basis of their motivational functions.

The separation of the affects into two groups based on their motivational capacity to activate (affects that evoke opening, approaching or energizing) or inhibit (affects that function by blocking action, restraining energy and motivates avoidance or withdrawal), is suggested as a potentially clarifying contribution to the study of affects in psychotherapeutic work (McCullough, 1997). This categorization is not necessarily clear-cut for different basic affective states, but is based on an evaluation of the complex motivational functions of affective and behavioral activation and inhibition for each relevant affect. Most affects are thought to be allocated in one of the two categories, but some (e.g. fear and disgust) might be placed in both and demonstrate a mixture of activating and inhibiting motivation.

The distinction between activating and inhibiting affects appears to be generally consistent with the theoretical and empirically tested notion of affects` differential tendency to motivate either approach-or withdrawal behavior (e. g., Eysenck, 1992; Clark & Watson, 1991). Converging evidence for the distinction between affective approach and withdrawal is derived



from neurobiology (Porges, 2009), microbiology (Kandel & Schwartz, 1983), animal conditioning (Panksepp, 2009) neuroscience (Carver, Sutton & Scheier, 2000), physiology and neuropsychology (Davidson, 1992).

The differentiation between activating and inhibiting affects also seems to be fairly consistent with Greenberg`s (2008) distinction between primary emotions and secondary maladaptive emotions. Primary emotions are the immediate and most fundamental reaction to a situation. Secondary emotions are the person`s emotional reactions to their own emotional responses. Greenberg stresses that primary emotions need to be accessed for their adaptive information and that maladaptive secondary emotions are learned responses that motivate “closing down” or withdrawal behavior and are no longer adaptive thus needs to be transformed or regulated. The theory surrounding Accelerated Experiential Dynamic psychotherapy (Fosha, 2009) also seems to have common characteristics with this conceptualization, focusing on the patient moving from distress through so-called state-transformation into an embodied (somatic) experience of core affect without defense, shame or anxiety.

#### **1.2.4 The aim of the present study**

Although APT specifically and STDP in general have been shown to be as effective as other therapies in the treatment of personality disorders, the processes and change–mechanisms through which these dynamic therapy–models work are not well investigated (Svartberg et al. 2004).

The aim of the present study is to examine the role and significance of the ATOS-variables Insight, Motivation, Activating –, and Inhibiting affect in psychotherapy, variables proposed by APT to be predictive of outcome (McCullough, 1997). This study investigates potential change in these four process variables and their interrelationships within a single-case observational design. It also attempts to examine and discuss whether such changes, if present, can be related to overall changes in symptoms, interpersonal problems and unhealthy personality functioning during the course of therapy and a follow–up period. The study examines the development on the process variables across sessions. The ratings of the process variables are qualified and contextualized by qualitative descriptions of excerpts from the course of therapy. The therapeutic process is differentiated according to an identification of the patient`s most severe affect phobias. The rated affect phobias are in turn analyzed and

described separately. Further analysis investigates the theoretically specified relationships between changes in the four process variables within sessions.

### **Research questions derived from APT**

- What are the central affect phobias treated in this course of therapy?
- APT's theory of restructuring of defenses would predict an increase in Insight and increase in Motivation across therapy. Restructuring of affect would be predicted to show an expected increase in Activating affects and decrease in Inhibiting affects, as affect phobias are desensitized. The current study investigates if these predicted between-session changes occur across the therapy-course for any of the affect phobias.
- APT theory also predicts in-session, sequential relationships between the process variables. Increase in Insight in one segment is expected to predict increase in Motivation in the subsequent segments. Increase in Motivation in one segment is expected to predict increase in Activating affect in the subsequent segments. Increase in Activating affect is expected to predict a decrease in Inhibiting affect in the subsequent segments. This study investigates if these in-session predictions can be seen in the course of therapy.

Finally, the study discusses the relationship between changes, or lack thereof, in the process variables of the ATOS and the development observed in the general outcome measures used in this therapy series, thus attempting to discuss and answer the question: How do the observed process variables of the ATOS relate to the general outcome of the treatment course?

## 2 Method

### 2.1 Procedures

#### 2.1.1 The patient

The patient was from a previously published randomized controlled trial of the effectiveness of APT and Cognitive Therapy for Cluster C personality disorders (Svartberg et al., 2004). In the initial interviews, the patient went through a Structured Clinical Interview (SCID-II; Spitzer, Williams, Gibbon, & First, 1990) and was diagnosed with obsessive–compulsive personality disorder in line with Diagnostic and Statistical Manual of mental disorders criteria (DSM-III-R, American Psychiatric Association, 1987). The essential features of the diagnosis are a pattern of perfectionism and inflexibility. The disorder is also associated with a focus on relative status in dominance–submission relationships. Stubbornness and avoidance of decision-making is often a problem, because of fear of making mistakes and receiving criticism. It is also associated with overly conscientiousness and a judgmental view of self and others. Low expressions of feelings are also frequently seen in this patient-population (*DSM-III-R*).

The patient was also administered a diagnostic interview with the intake evaluator who used the Structured Clinical Interview to obtain *DSM-III-R* Axis I diagnoses (SCID-I; Spitzer, Williams, Gibbon & First, 1990). The patient did not fulfill diagnostic criteria for any Axis I disorders.

The patient was randomly assigned to the APT condition and received weekly therapy, forty sessions in sum. All sessions lasted about fifty minutes and were videotaped. The case was randomly selected for this study and the process-measure raters were blind to the outcome of the treatment.

The patient was a forty year old man, seeking help through his job's health service. The patient was in a full time job at the time of therapy. The patient's problem description in the initial therapy sessions was about feelings of inferiority and fear of not being good enough, at work and with his family. The patient reported distress and described diffuse anxiety

symptoms including nervousness, pain in stomach and uneasiness connected to the job situation and especially in relation to one colleague he perceived as harsh and dominant. At the beginning of therapy, the patient was married, living with his wife and their two kids. The patient reported marital problems that had been going on for a while. He was missing closeness in the relationship, and felt a growing distance between him and his wife. The patient went through a divorce during therapy, and his wife and one of his child moved out. The patient expressed views of therapy as a room where he could have “a sort of breathing space”, and was motivated to have a look at “what is going on” with him.

### **2.1.2 Treatment**

The therapist was a Norwegian clinical psychologist, aged mid-fifties, working at a health clinic in Norway. The therapist was enrolled for a program of APT for personality disorders and received a two-day supervision seminar from Dr. Leigh Mc Cullough. The therapist treated one patient as a training exercise before treating the patient in this study. The therapist participated weekly in 2-hour video based peer-supervision meetings where the treatment was systematically reviewed for adherence to treatment protocols (Svartberg et al., 2004).

## **2.2 Measures**

### **2.2.1 Outcome measures**

Outcome assessment consisted of self-report measures. Symptom distress was assessed by the Global Severity Index (GSI) of the Symptom Check List-90, revised (SCL-90-R; Derogatis, 1983). The total mean score of the full version (127 items) of the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno & Villaseñor, 1998) was used to assess patients' general problems with assertiveness, intimacy, sociability, submissiveness, control, and responsibility for others (IIP-Global). To assess personality pathology, the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1984) was used. The 175 item-questionnaire of MCMI reflected Cluster C personality disorder scales of avoidant, dependent-submissive, obsessive-compulsive, and passive-aggressive which have proved diagnostically efficient and congruent with *DSM-III-R* personality disorder diagnoses (Svartberg et al., 2004).

Table 1: Pre-, post and follow-up scores on the three outcome measures.

<i>Measures</i>	<i>Pre treatment</i>	<i>End treatment</i>	<i>2 year follow- up</i>	<i>Cut off scores for normal samples</i>
SCL- 90-R	0.82	0.36	0.11	1
IIP	1.31	1.43	0.42	0.88
MCMI-III	54	50.25	36.5	74

The outcome data yields somewhat ambiguous results (table 1). At the end of treatment the GSI of the SCL-90-R did show a decrease in reported symptoms from moderately symptomatic to an unsymptomatic level (Tingey, Lambert, Burlingame & Hansens, 1996). The measures of interpersonal problems (IIP-Global) and personality (MCMI–III) show no significant change from pre treatment to the end of treatment. The outcome measures at two year follow-up show a further decrease in reported symptoms indicating a highly unsymptomatic status on the GSI and depict a significant decrease in reported interpersonal problems (IIP-Global) and personality problems (MCMI – III) related to Cluster C personality disorder. Reliable and clinically significant change was calculated according to the principles outlined by Jacobsen and Truax (1991) for clinical and normal reference samples with overlapping distributions (as is the case for the clinical sample to which the patient belonged pre–treatment and the relevant reference sample) (Derogatis, 1983). The calculations indicated no reliable changes at termination, but reliable and significant change on all measures on the two year follow–up.

## 2.2.2 Process measures

### ATOS

Videotaped sessions from the course of therapy were analyzed using the Assessment of Therapeutic Objectives Scale (ATOS; McCullough et al., 2004). The ATOS is a method for assessing psychotherapy process by measuring observed patient behavior related to objectives in therapy. It is a multidimensional rating procedure derived from McCullough and colleagues clinical work and videotape analysis of therapy and aims to capture practically and theoretically relevant objectives in the therapeutic process. The ratings indicate to which

degree the patient seems to absorb the therapist's interventions or show objective-related behavior. The ATOS consists of seven subscales: Insight; Motivation, Activating affect, Inhibitory affect, New emotional learning, Sense of self and Sense of others. Four of the variables were used in this study and include: Insight, Motivation, Activating affect and Inhibiting affect.

The videotaped therapy sessions were divided into ten-minute "segments" and rating was done after each segment. The coding was done by first qualitatively deciding on the "core affect phobia" focused on in the segment. The core affect phobias in the ATOS are identical to the Activating affects proposed by APT and include: anger/assertion, grief/sorrow, enjoyment/joy, interest/excitement, closeness/tenderness, sexual desire, positive feelings for self and healthy fear. The rating of the four process variables were then performed in relation to the chosen core affect phobia in the segment. All process variables are rated on a 1-100 point scale (see appendix). The scale is defined and grounded in observable verbal and non-verbal behavior. A more detailed description of the items follows.

The Insight variable measures the level of insight, understanding and awareness the patient shows regarding maladaptive/defensive patterns. The variable contains two main components. One component is the patients' clarity and fullness of verbal descriptions of maladaptive patterns of thoughts, feeling, and/or behaviors, exemplified with explicit examples. The second main component is the degree of ability to state why and how maladaptive/defensive patterns began and how they are maintained. This includes the patients' description of the maladaptive responses secondary gain, meanings, causes, and with whom they occur. High levels of Insight are given for clear and detailed descriptions of maladaptive patterns and awareness of how these pattern are transferred from past to present and maintained. Moderate levels of Insight include partial descriptions of maladaptive patterns and vague past-present links. Low levels of Insight include minimal or no recognition of maladaptive behavior, and reluctantly elaborating further when the therapist points out maladaptive patterns.

The Motivation variable describes the level of desire the patient has to give up maladaptive patterns of thoughts, feelings, and/or behaviors related to the affect phobia. It describes also the degree of dislike, undesirability or sorrow specifically about the costs of defenses or maladaptive behavior. High levels of Motivation include very strong wishes to change and strong discomfort related to maladaptive behavior. Moderate levels of Motivation include some wishes to change, but also moderate defensiveness/resistance. Low levels of Motivation

are described as a very low desire to change, much resistance and description of maladaptive patterns in so-called ego-syntonic or self-congruent ways.

Activating affect indicates the intensity of arousal of adaptive affect experienced. The rating is of the predominant (phobic) affect in the segment. The peak/highest degree of arousal is rated based on affective arousal as shown in facial expression, vocal tone, non-verbal behavior or charged verbal statements. Rating of Activating affect takes into account the duration of the affective arousal and the sense of relief observed after the experience of feeling. The scale does not measure inappropriate, maladaptive arousal, which is considered as defensive or avoidant use of affect. Examples of high levels of Activating affect include strong affective arousal, full and vivid feelings and memories which are sustained for some time and include ability to modulate and control affect and integrate it with other affects. Moderate level of Activating affect includes moderate affective arousal, duration, moderate relief and moderate holding back. Low levels of Activating affect include very low or no affective arousal, barely visible/audible signs of feeling of short duration, and no relief.

Inhibitory affects describes the level of anxiety/panic, guilt, shame/humiliation, contempt/disgust and pain/anguish in the segment. The coding is of overall intensity of observable emotion shown by verbal report, vocal tone, and non-verbal behavior with attention to physiological signs of inhibitory affect. Some examples of anxiety are trembling, tension, shifting, restlessness or twitching. Shame or guilt can be observed as looking down, blushing, lowering tone of voice, hands over face or covering eyes, or head down. There are as mentioned earlier, appropriate levels of all these affects, but only maladaptive inhibition is rated here. High levels of Inhibitory affect may be exemplified with a tone of voice that is extremely hesitant, shaky or sighing. Body and muscles are trembling and tense. Moderate levels of Inhibitory affects are indicated by e.g. moderately hesitant tone of voice, moderately tense muscles and rigid body movements. Low levels of Inhibitory affects are indicated by low levels of anxiety, guilt, shame or pain as shown by verbal report and or non-verbal behavior.

The results of five reliability studies in Norway, Italy and USA indicate that ATOS is a psychometrically sound instrument showing moderate to excellent reliability (McCullough et al., 2004). In the reliability studies the raters coded patients' responses to STDP and indicated a clear dose-response relationship between training on scales and reliability.

### **2.2.3 Raters and inter-rater reliability**

Raters received a two day course in the process instrument (ATOS) before training. Training was conducted by coding APA tapes and comparing scores with established “gold standards” scored by “master coders”. Reliability training was conducted under supervision of “master coders” and reliable scoring was achieved when coders received an Intra-class Correlation Coefficient (ICC; Shrout & Fleiss, 1979) of .50 or above on ten consecutive measurement points. Raters in this study were randomly selected from a pool of coders and had approximately 100 hours of training before coding the material.

Reliability between raters in this study was estimated by examining ICCs in an internal consistency type, two way random effects model using average measures across raters. The reliability was .77 for insight, .75 for motivation, .63 for activating affect and .76 for inhibiting affect.

### **Rating procedure**

Videotape analysis of 33 of the 40 therapy sessions were performed. The seven missing sessions are due to tapes not functioning. Coding in teams of two coders was done to prevent rater drifting. When coding in teams, the raters scored each ten-minute segment separately and then discussed each rating and agreed on a consensus score. Session 3, 4, 17, 23, 25, 26, 27, 30 and 35 was coded by a team of two coders. Session 1,2,9,13,14,15,18-24,28,29,31-34 and 36-40 was coded by one of the coders in the team.

## **2.3 Analyses**

### **2.3.1 Statistical procedures**

To examine change in the process variables, the data was collected within each session, using segment scores (circa 5 segments pr session), and across therapy sessions (using mean scores of each session).

Analyzing between-sessions variation in the process variables was performed by separating data based on the core “affect phobia” rated in each segment. This was done to examine differences in the process variables regarding the diverse affect phobias thus differentiating



between affects (i.e., investigating if the process variables changed differently for affect phobia against e.g., “anger/assertion” than for e.g., “grief/sorrow” etc.). Depicting data was done by using scatter plots. Change in process variables during the course of therapy for the diverse affect phobias was examined by fitting linear regression models to the data, modeling each process measure as a function of “time”.

Within-session change due to predicted sequential/temporal relationships between the process variables was examined by using Auto-Regressive Integrated Moving Average (ARIMA) time-series analysis (SPSS 18.0). ARIMA is an analysis used to determine if present data points can be predicted from past data points. As the therapy sessions were divided into ten minutes segments, and ATOS rating was done after every segment, the segments represented the data points (lags), (i.e. the lags represent data points at a given time). The temporal correlation between variables is called cross-correlations. The ARIMA was used to cross-correlate given process variables in a given segment (lag 0) with another process variable in the next segment (lag 1) or in the segment thereafter (Lag 2) to examine the predicted temporal relationships between the process variables. ARIMA modeling involves three stages:

- Longitudinal data are usually correlated over time (autocorrelation) and may cause misleading results (e.g., Tsay & Tial, 1984). The first stage includes identification of ARIMA parameters due to autocorrelation and correlated error. The autocorrelation and correlated error was first examined by using Box-Ljung tests in SPSS. The results were matched with established models (Box, Jenkins & Reinsel, 1994) to select right parameters. The data indicated that current observations of the process variables in the series were correlated with themselves at lag 1. A model of first order autoregressive component was thus selected to produce uncorrelated residuals in all process variables.
- The second stage includes testing the chosen parameter to examine if they contribute significantly and satisfactorily to delete autocorrelation and correlated error. When removing autocorrelation and correlated error, new variables of uncorrelated residuals were calculated.
- The third stage includes cross-correlating the process variable residuals. The residuals of the process variables were thus cross-correlated to examine the predicted sequential relationships.

In this study, we examined Insights predicted effect on Motivation, i.e. if the level of Insight in one segment (Lag 0), could predict level of Motivation in the next segment (Lag 1), or in the segment thereafter (Lag 2). In the same way, we examined the predicted relationship between Motivation and Activating affect, and Activating affects predicted effect on Inhibiting affect.

In addition to analyzing the predicted sequential relationships, all potential relationships between all process variables were examined using exploratory ARIMA analyses.

It was not distinguished between the different affect phobias when conducting time-series analysis. This was done in order to maintain enough measurement points.

### **2.3.2 Qualitative descriptions**

Detailed notes of the process were taken when watching the therapy, focusing on the process variables. The notes included specific quotes of the patient's statements during the course of therapy. Qualitative inspection of the dialogue was performed after conducting the quantitative analyzes. The excerpts of the patient's statements were used to describe and exemplify the basis of the ATOS scorings in the results section. The quotes used in the results section were selected to demonstrate the typical/general scorings on the ATOS, and the typical higher or lower ratings.

Quotes from the therapy course were also collected (in retrospect after coding was finished) to illuminate the therapeutic process and are complementary data, included to evaluate and discuss in what ways the ATOS variables may relate to the general outcome of the treatment course.

## 3 Results

### 3.1 Affect phobias in therapy

The results indicate that affect phobias of primary focus in the therapy sessions mainly related to “positive feelings for self”, “grief/sorrow” and “anger/assertion” (table 2).

Table 2: Distribution of affect phobias rated across therapy.

% of segments	Affect phobias
50 (n=76)	Positive feelings for self
23 (n=35)	Sadness/grief
18 (n=27)	Anger/assertion
9 (n=14)	Other
100 (n=152)	Sum

### 3.2 Predicted between-session change in the process variables across therapy

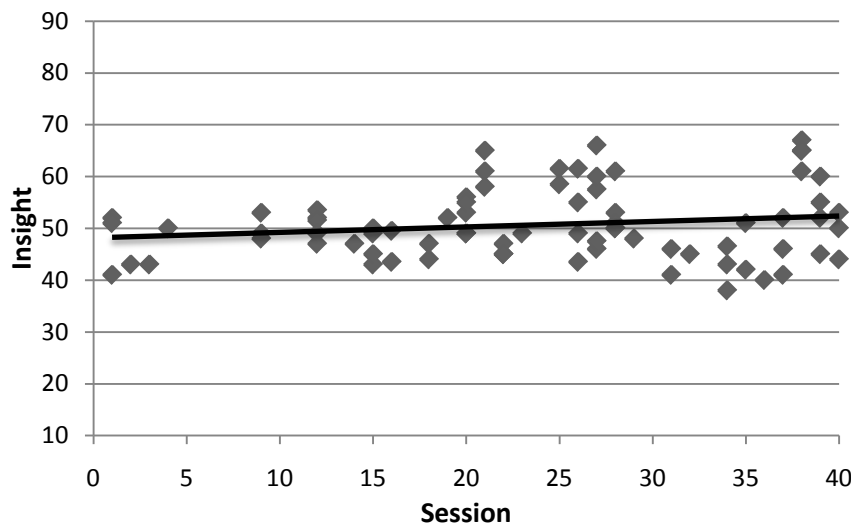
The following section describes the ATOS scores across therapy, including a more detailed description of the basis for the coding on the four process variables. Qualitative descriptions are included to supplement the quantitative assessments given by the ATOS. The four process measures are analyzed and described for each affect phobia respectively.

#### 3.2.1 Treatment of affect phobia against “positive feelings for self”

##### Insight (defense recognition)

The level of Insight ranged from 38 to 67 on the ATOS through therapy (figure 1). This indicates a variation from low recognition to high-moderate recognition of maladaptive patterns of avoiding positive feelings for self. The regression line does not identify a

significant increase in level of Insight through therapy (table 3). The scatter plot, however, indicate a greater variability in rating as therapy progressed.



*Figure 1:* Shows ratings of Insight regarding affect phobia against positive feelings for self through the course of therapy.

### *Qualitative descriptions of Insight regarding the affect phobia against positive feelings for self*

The Insight score is generally in the lower moderate range indicating that the patient often describes maladaptive patterns, sometimes with clear examples. Eg. Does the patient describe early a pattern of trivializing own needs in relation to his workspace and wife (4)<sup>3</sup>.

Elaborating on this he says, "it affects me all the time that I am caring, putting the needs of others above mine". The patients focus is on his job situation were these issues are specifically relevant when he fears receiving critique and not being good enough. He says, "I have a tendency to blame myself even if I doubt I am guilty of doing wrong" (9). He adds, "It brings down my self-esteem this way", and says that it "reduces me as a person, making me feel inferior and unappreciated in the eyes of others and myself". Indicating insight into maladaptive behavior of suppressing own opinions and needs and that this is related to his feelings of inferiority.

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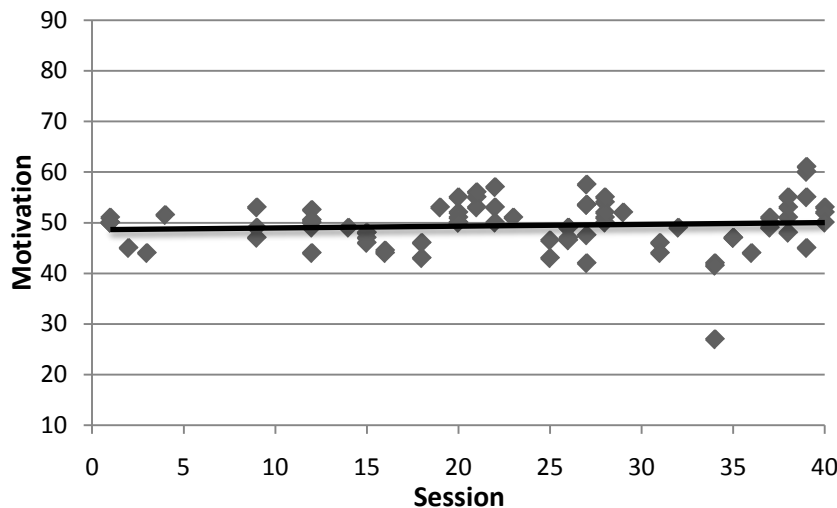
<sup>3</sup> The numbers in parentheses indicate from which session the quote or referred episode is selected. When quotes are not followed by a parenthesis, they are from the same session as the previous parenthesis indicates.

There are sessions with elevated Insight in the moderate to high levels where he has references to past-present links, sometimes mentioning why maladaptive behavior occurs. For example when he tells the therapist that he was "hushed on" (20) by his parents and that the children "should be seen, but not heard". He describes that he was often silent and spent his time listening rather than speaking when growing up, saying, "I waited to say anything until I was asked, I have probably taken this with me later in life" indicating reference between past experiences and the present situation. He also describes memories of being reticent, subdued and compliant, and that "spontaneity was strangled". The patient elaborates that he "accepted to be silent, but that it was a false self". He elaborates further on the origin of this behavior and explains that his father made most decisions for him, treating him as a child when he was an adolescent. He also describes receiving little encouragement from his parents to explore things saying "I did not receive much stimuli at home, I was not allowed to try things out".

Exploring further on the origin of his low self-esteem he explains that he tried to be like his older brother and was included with his friends. But that he "ended up trailing along, I fell short" (23).

### **Motivation (relinquishing of defenses)**

The Motivation ranges from 42 to 60 on the ATOS most of the time (Figure 2). The scores indicate a relatively stable level of motivation to give up maladaptive patterns of avoiding positive feelings for self in the low-moderate to high-moderate area. The ratings reveal that the patient generally expresses wishes and openness to change and some discomfort over maladaptive behavior, but also moderate resistance or defensiveness. The regression line indicates no significant increase in Motivation across therapy (Table 3)



*Figure 2: Shows ratings of Motivation to give up maladaptive patterns of affect phobia regarding positive feelings for self through therapy.*

***Qualitative descriptions of Motivation to change affect phobia against positive feelings for self***

Examples of this general level of low–moderate Motivation include that the patient expresses concern and distress connected to the pattern of “being at the mercy of others” (4). He says he is self-effacing and “becomes negligible, almost a slave”(18). He expresses sadness when describing “feelings of not being heard”. He expresses ambivalent motivation to change by saying, “I feel stuck in this role”, “I am afraid of not having the sufficient skills” (28) and doubts that his needs would have been heard if he expressed them. There is one session where the patient is very resistant to change as he describes his affect phobia in a so–called ego-syntonic way saying, “ this is the way I am, I have always been like this”, indicating very low motivation to change (34).

The patient exhibits examples of higher motivation on some occasions. He indicates curiosity and engagement in finding out more about himself as he borrows a book in the library and describes it as a means to "get to know myself and how things work" in relation to his colleagues (20). This is coded as an instance of general motivation to understand himself and change in a more adaptive and self–caring way. In the last session the patient expresses motivation to change his behavior of being dependent on others and gain self-confidence as he says “I can not be dependent on others to feel safe anymore” (40).

### Activating affect of positive feelings for self (affect restructuring, affect experiencing)

The level of positive feelings for self is rated between 20 and 40 most of the time in therapy (figure 3). This indicates a very-low to low affective arousal through therapy. The ratings indicate that there are minimal or barely visible/audible signs of feeling and little relief most of the time, but with some episodes of elevated affect. The regression line does not reveal a significant increase in Activating affect through therapy (table 3).

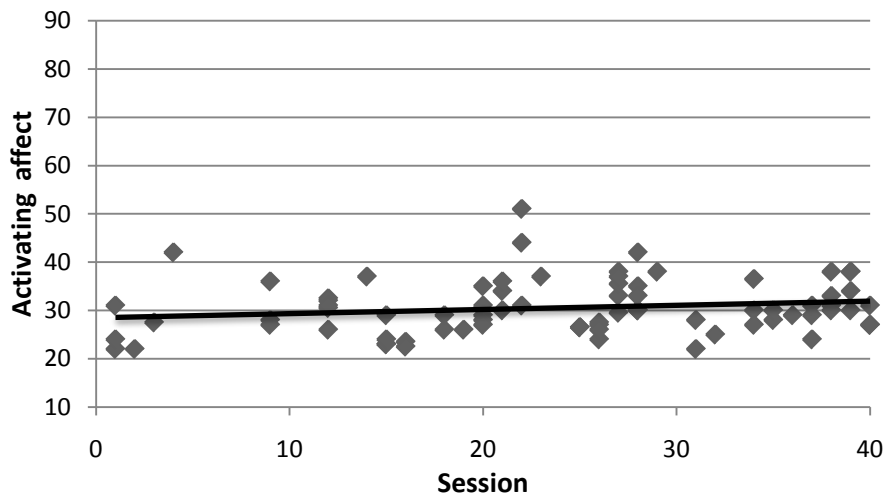


Figure 3: Shows activation of positive feelings for self through therapy.

### *Qualitative descriptions of positive feelings for self*

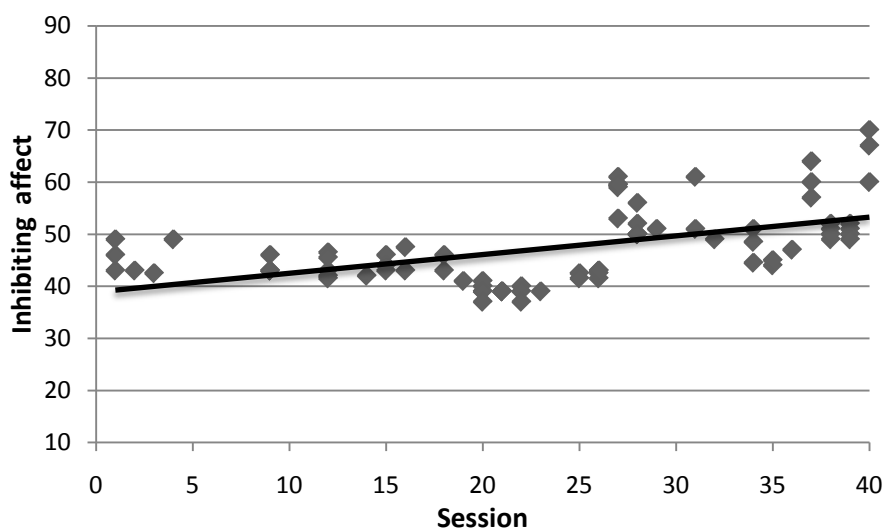
The patient expresses feelings of inferiority and low self-esteem, relating to his performance at work and to his identity as a family man, where he feels unsuccessful. The general low affect level is manifested/described as the patient speaks in a flat and monotonous tone through therapy.

There are four incidences of elevated affect (round 40 on the ATOS), ranging in the low-moderate, to moderate level of arousal. The patient shows an indication of positive feelings for self (self-entitlement) early in therapy (4), when he describes, in an aroused manner, how he deserves to be able to express his needs to his wife. The rating is based on the emotional activation as he says a few tender words and speaks openly with some emotional content. Later, in therapy (22), the patient talks in an emotionally affected way, about a picture he has found of himself as a young boy, expressing self-compassion. When staring at the picture he describes that he felt a “wish to raise and take care of the young boy who looked vulnerable and pitiful”. He adds that he wanted to help him “be himself on his own terms, so he could

keep his confidence”. He also says, “I wish I have stepped in and done something”. This is coded as medium level of positive feelings for self because of the intensity of emotional experience observed, length and relief. Another incident of a moderate level of Activating affect is noted when the patient describes a proclamation of a speech in front of some acquaintances, which he describes “went fine!”. He felt confident with the people around him remarking that “it was a good experience”. He smiles and looks proud of himself saying, “yes I can”, indicating positive feelings for self (self-confidence) (28). In later sessions (38 and 39) the patient show signs of self-compassion when he describes how he see himself growing up being hushed at and having to be quiet. Although relatively low level of Activating affect is coded, the patient exerts some ability to care for himself in the late sessions saying, “I need peace to find myself and establish a life of my own”.

### **Inhibitory affect (affect restructuring)**

The Inhibitory affects range between 37 and 49 in sessions one to twenty-six. This indicates a low to low-moderate level of Inhibitory affect. From session twenty-seven and onward the level of Inhibitory affect is mostly in the moderate- to high moderate level (figure 4). The regression line indicates a significant increase across therapy (Table 3).



*Figure 4:* Shows the rating of Inhibiting affects in segments of affect phobia against positive feelings for self through therapy.



*Qualitative descriptions of Inhibitory affects in segments of affect phobia of positive feelings for self*

The patient generally describes a lot of worries and anxiety related to fear of not being good enough at work, fear of being yelled at and not having control over the situation. He describes physical symptoms of anxiety, such as a lump in his stomach, pressure in his chest etc, but there is not much visible anxiety related to this early in the therapy. The patient also expresses inhibiting feelings of guilt regarding blame towards his parents for “what has gone wrong” (22) after exploring the home environment within his family and adds that his low self-esteem typically was self-induced and that he cannot remember receiving many explicit remarks from them.

The predominant Inhibiting affect through therapy is anxiety and there is an increase in this affect from session twenty-seven as the patient begins the hour by asking, “Where does this end?” (27). The patient asks for specific assignments because he is “afraid of ending up in a situation of helplessness”. The elevated anxiety seems related to the patients fear of being alone as it becomes clear to him that his wife is moving out, and that he is dependent on managing life on his own. The patient seems aroused and scared and describes that he “does not feel he has enough confidence to survive” on his own.

There is a further increase in anxiety in the subsequent sessions and a peak rated in the last session. The patient describes an episode of being struck by anxiety between sessions and talks in a distressed way about his fear of being left alone now as he ends his therapy. There are clear signs of affect as he breathes heavily, swallows and says, “It is a security that will not be there anymore. I am afraid of ending up in a situation which paralyses me in a way”(40). He says, “anxiety gets too big and I am afraid it overshadows the knowledge I have gotten from therapy”, which is coded as the highest score of Inhibitory affect in the course of therapy. The anxiety does not seem to be direct phobic responses to positive feelings for self, but the core affect phobia coded in these segments are feelings for self, and the anxiety is thus coded in relation to this.

Table 3: Descriptives and regression coefficients for the process variables regarding affect phobia against positive feelings for self

<i>ATOS variables</i>	<i>St. deviation</i>	<i>Mean</i>	<i>Adjusted R square</i>	<i>B</i>	<i>SE</i>	<i>t</i>
Insight	6.9	50.7	.03	.11	.072	1.47
Motivation	4.9	49.4	.01	.04	.052	0.68
Activating affect	5.6	30.6	.03	.09	.059	1.47
Inhibiting affect	7.3	47.5	.28 **	.36	.066	5.47

\*p< 0.05. \*\*p< 0.01.

### **Summary: Treatment of affect phobia against positive feelings for self**

In this therapy, the patient spends a lot of time to talk about and explore the patterns of trivializing own needs, taking an unfair amount of responsibility and looking down on himself. The patient gains insight into some plausible reasons for the maladaptive pattern linking similarities between past relationships and relationships in the present. The patient shows some motivation to change the maladaptive pattern by expressing distress connected to live by others demands and repeatedly reports discomfort and sadness attributed to the costs of the defensive behavior of not showing self-respect and self-entitlement. On the other hand, he also expresses some resistance and defensiveness throughout therapy, as he doubts that change is possible and describes maladaptive patterns in an ego-syntonic and helpless way. Positive feelings for self are rated in the low level most of therapy. There are some episodes during therapy that shows elevated affect, indicating incidents of exposure of Activating affect. The general level of experiencing positive feelings for self does not increase significantly during therapy. The Inhibitory affects of anxiety and guilt are measured to be in the low-moderate area in the first twenty-six sessions. A significant increase in anxiety is rated thereafter, possibly connected to the escalating doubt in being on his own as he is ending therapy and his wife and one daughter has moved out. The other two process variables show no significant change during the course of therapy (table 3).

### 3.2.2 Treatment of affect phobia against “grief /sorrow”

#### Insight (defense recognition)

The ratings on the Insight variable vary between 36 and 60 on the ATOS indicating a low to moderate level of Insight and the scatter plot indicates a greater variance in scorings as therapy progressed (figure 5). The regression line shows a slight but significant increase in Insight through therapy (table 4).

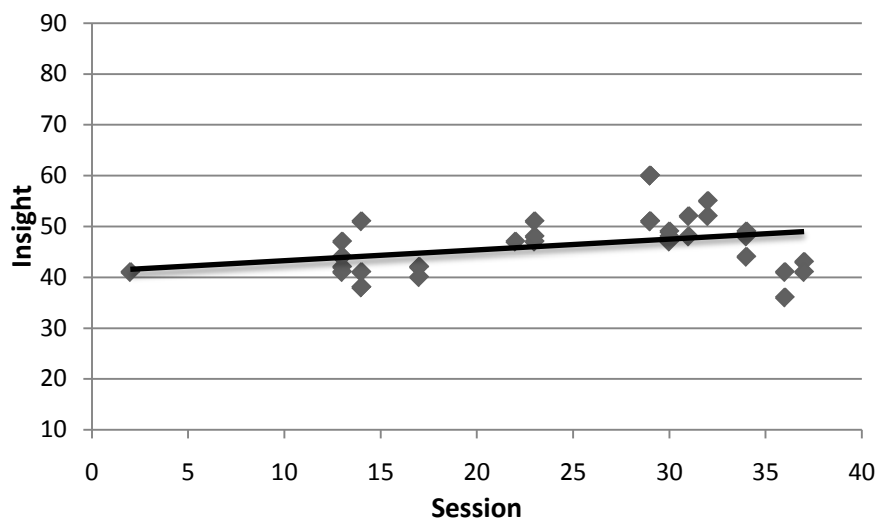


Figure 5: Shows level of Insight regarding affect phobia of grief/sorrow across therapy.

#### *Qualitative descriptions of Insight regarding the affect phobia against grief/sorrow*

The scorings in the early sessions of therapy are in the low-moderate level, indicating that the patient describes maladaptive patterns in vague and general descriptions. E.g. when the patient describes a fear of feeling sorrow related to his imminent divorce. Exploring the feelings, he says, “I fear losing my grip, losing control of myself, become apathetic, and not being able to do anything” (13).

Further elaborating on the avoidance of grief, they explore the patients experience with earlier losses. The patient says he did not feel grief when his father died. The patient lost his older brother when he was even younger (seven years) and describes feelings of distress, as if it was "unreal that he was gone" (23). He says, “My parents mourned, but I was not a part of it, I pulled myself away, I did not like it there, I fled”.

He says he felt more distress by his parent's reactions of crying, "an uncomfortable feeling", than with feelings relating to his brother's death. Elaborating on the mourning process he says "I definitely had feelings, but I was very much alone, I did not talk much about my brother's death". He says "I can't remember being hugged (in that occasion), I certainly had a need for comfort but never asked for it, I was shy, withdrawn, left to myself", and that "our family relationship lacked natural physical contact".

Low levels of Insight is rated when the patient acknowledges maladaptive behavior only when pointed out by the therapist. E.g., when the therapist points out the patient's avoidance of feelings of grief as he just wants to look at the breakup's positive sides and describes defensive denial by engaging in leisure activities or by changing the subject in therapy (14). The patient agrees that he fears to be paralyzed by sadness and sorrow, but looks for causes of his distress elsewhere, asking the therapist if it can be something with his age or somatic conditions that causes the distress, indicating low Insight.

Moderate levels of elevated Insight are rated in later sessions. The patient shows insight into a pattern of avoiding feelings of grief in a session as he says, "it has dawned on me that my wife and daughter are going to move out. Maybe I have not dared to think about it before?" (29) And precedes, "I have exaggerated the positive sides of it!" In later sessions he reports a terrifying experience where he was overwhelmed by loneliness, sorrow and helplessness. The insight scores in the latest sessions vary a great deal as he seems to be alternating between facing the fact of his divorce and denying it.

### **Motivation (relinquishing of defenses)**

The ATOS ratings range from 36 to 52 which indicate low to moderate Motivation to give up maladaptive patterns (figure 6). No significant change in level of Motivation is noted fitting a regression line to data (Table 4).

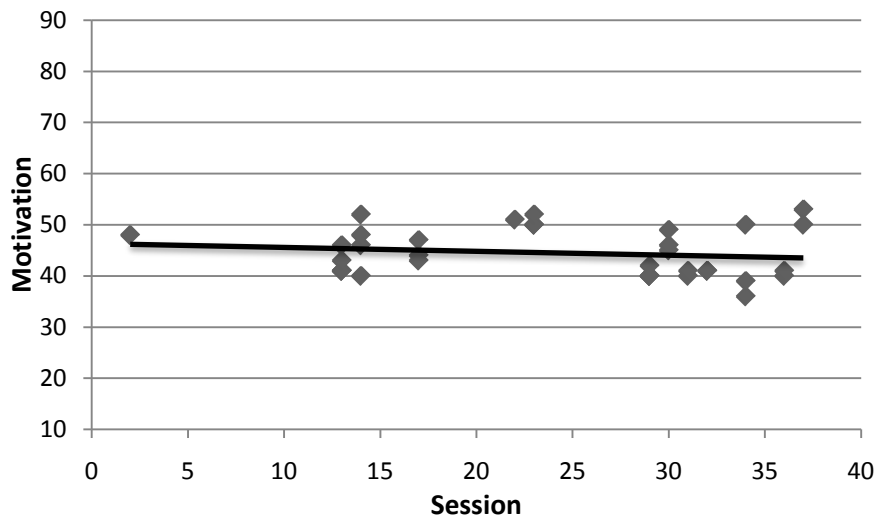


Figure 6: Shows ratings of Motivation to change maladaptive patterns of grief/ sorrow phobia through therapy.

#### *Qualitative descriptions of Motivation to change affect phobia against grief/sorrow*

The general motivation to grieve over the divorce and breakup of his family is low and dominated by much ambivalence and resistance. The therapist confronts the patient's defensive behavior by pointing out that he is avoiding the feelings of sadness and grief several times through therapy. The patient feels pushed by the therapist saying, "I feel anxious about you forcing me to face some of the discomfort" (14) indicating low Motivation to challenge the defensive pattern of avoiding feelings. At one point he orders the therapist to "not interfere in how I work with myself!" (29). The patient says that he is motivated to hold the painful feelings back and refers to the experience where he was "hit" by feelings of being left alone. He also says "I prefer to feel joy! I want the good feelings to prevail. You are trying to tear that down, I do not like it" (34). Low score of Motivation was also rated as the patient says "I've always thought like this, pushed the uncomfortable in front of me. I try not to think about it so it might go away, I avoid it".

Later in therapy, as his wife and one daughter moves out, he indicates that he knows the therapist is right saying, "feelings must be processed, and by that gotten rid of" and "I do not regret (the divorce), but it is a process I must go through" (29). He also says that he wants to believe this, indicating moderate Motivation to approach the feelings (36). Moderate Motivation to explore feelings of grief is also coded in relation to elaboration of earlier losses.

### Activating affect Grief/sorrow (affect restructuring, affect experiencing)

The ATOS scores range between 22 and 41 which indicate a very low to low-moderate level of Activating affect (figure 7). The Activating affect of grief/sorrow is predominantly coded in the low area. There are a few episodes of elevated grief/sorrow noted at the low-moderate level (around 40 on the ATOS). The regression line does not indicate a significant change in level of Activating affect through therapy (table 4).

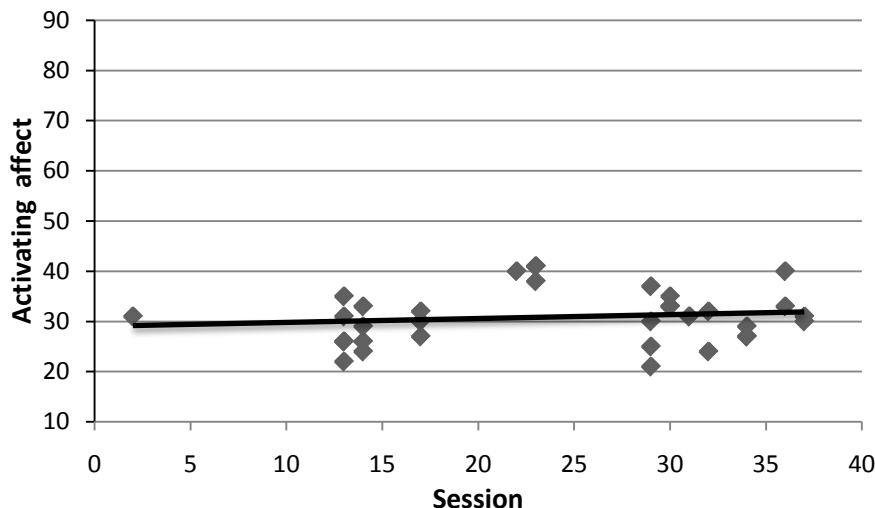


Figure 7: Shows activation of grief/sorrow through therapy.

### Qualitative descriptions of grief/sorrow

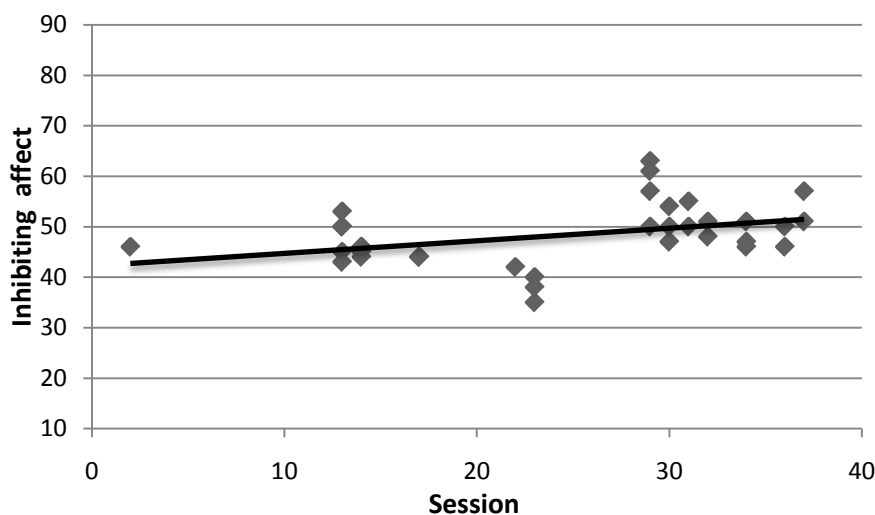
The generally very low level of grief/sorrow is for example rated as the patient early in therapy describes his forth-standing divorce in a relatively unaffected way (2), showing little activating arousal with low intensity or endurance. When the patient later in therapy explains that they have decided to get divorced, it is only noted low affective arousal with slight signs of sadness that is quickly inhibited (13).

The highest scores of grief/sorrow is rated when earlier grief reactions is explored in therapy reaching a low-moderate level. He describes remembering feelings of sadness after the loss of his brother. He stays with the memories and elaborates in an emotionally affected way, looking sad, which is coded at the medium level of affective arousal (23). In another occasion, when the patient elaborates on his personal history, he explains how he had seen a picture of himself as a young boy and that he now feels sorry for "himself". He says he feels sadness and grief when talking about being subdued and describes feelings of wanting to "hold his arms around the boy (i.e. himself), comfort him and let him find himself" (22).

A somewhat elevated level of emotional arousal is coded when he says, “my private life has meant the most to me, but it is of no more use for me” (29). At the end of therapy (36) the patient displays some grief when he describes an episode of saying goodbye to his wife and daughter. The rating is in the low affective arousal level as the feelings seem to pass quickly or are being held back.

### **Inhibitory affect (affect restructuring)**

The level of Inhibitory affect range from 35 to 63 on the ATOS (figure 8). The regression line indicates an increase in Inhibitory affects from low-moderate to high-moderate level through therapy (table 4).



*Figure 8: Shows rating of Inhibiting affects in segments of affect phobia against grief/sorrow through therapy.*

### ***Qualitative descriptions of Inhibition in segments of affect phobia against grief/sorrow***

The lowest level of Inhibition is coded when the patient elaborates on earlier losses (22 and 23).

Low-moderate level of Inhibition is rated when the patient talks about his forthcoming divorce (13 and 14). He expresses some anxiety of “losing an anchor and safety in life” and adds “I am losing control of myself, I’m not able to do anything” and “I fear that the grief can take a strong hold”.

His words describe a dramatic and profound fear as he adds, “I do not know how far away from harming myself I am”. However, there are few visual signs of the fear he describes as his body language appears calm and relaxed.

An increase in anxiety is observed in later sessions when the patient says that it has begun to make an impact on him that his wife and daughter are moving out. He says that he has been “in touch with the feelings of loneliness and sadness” (29) and that he is “afraid of it, afraid they will take the upper hand”. The patient seems aroused and distressed when the therapist points out his defense of avoiding feelings, and he says “I feel anxious about you forcing me to face some of the discomfort!”. The patient describes a panicky-stricken response when he is overwhelmed with feelings of “being alone and abandoned” (32). He says he “fears to fall into a depression and become paralyzed”. The therapist keeps on challenging the patient’s defense of avoiding the painful feelings related to his divorce. The patient says that he is uneasy when talking about what he denies, or otherwise holds it at a distance. He adds that it is “the feeling of losing control, feelings of being out of balance” (34). And that he doesn’t know “what will happen if I approach the bad feelings”.

Table 4: Descriptives and correlations coefficients for the process variables regarding the affect phobia against grief/sorrow

<i>ATOS variables</i>	<i>St. deviation</i>	<i>Mean</i>	<i>Adjusted R square</i>	<i>B</i>	<i>SE</i>	<i>t</i>
Insight	5.8	46.2	.12 *	.21	.101	2.09
Motivation	4.6	44.4	- .01	-.07	.084	0.88
Activating affect	5.3	30.8	- .01	.07	.097	0.77
Inhibiting affect	6.0	48.2	.13 *	.25	.102	2.43

\*p< 0.05. \*\*p< 0.01.

### **Summary: Treatment of affect phobia against grief/sorrow**

The patient gains insight into a pattern of avoiding unpleasant feelings of grief/sorrow. He also elaborates on the origin of the defensive pattern of avoiding sadness by exploring earlier experiences with grief reactions and how they were handled in an environment of low emotional expressiveness. There seems to be some exposure of grief related to earlier loss of his brother and looking back on himself as a child.

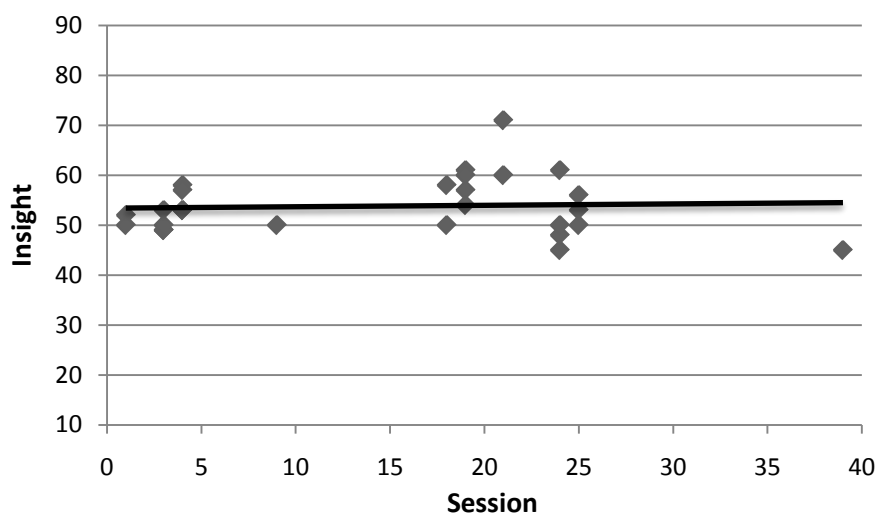


His motivation to challenge the avoidance of feelings of grief related to his divorce is generally low, as he for example fears “losing control and become apathetic”. The patient seems to be avoiding the fact that his wife and child are moving out. He seems overwhelmed by anxiety as the end of therapy is approaching. The regression lines indicate an increased level of Insight and Inhibiting affect across therapy. The level of Motivation and Activating affect show no significant change (table 4).

### 3.2.3 Treatment of affect phobia against “anger/assertion”

#### Insight (defense recognition)

The level of Insight concerning anger phobia is, with one exception, ranging between 45 and 61 on the ATOS, indicating low-moderate to moderate recognition of maladaptive patterns (figure 9). The level of Insight is relatively stable and the regression line does not show a significant increase in level of Insight scored through therapy (table 5).



*Figure 9:* Shows the scoring of Insight regarding affect phobia of anger/assertion across therapy.

#### *Qualitative descriptions of Insight regarding the affect phobia against anger/assertion*

The general level of moderate Insight with descriptions of maladaptive behavior is exemplified as he early in therapy describes his own pattern of avoiding confrontations.

He says that he “slips into a role” (1) at work where he is anxious, uptight, and where he “puts a lid on his anger”. He describes suppressing his anger because he is afraid of getting “the same back” (4), saying, “I don’t want to yell, I have trouble with being yelled at myself”. Indications of a vague link between past and present is noted as he adds that “this has been going on for a long time, through childhood”.

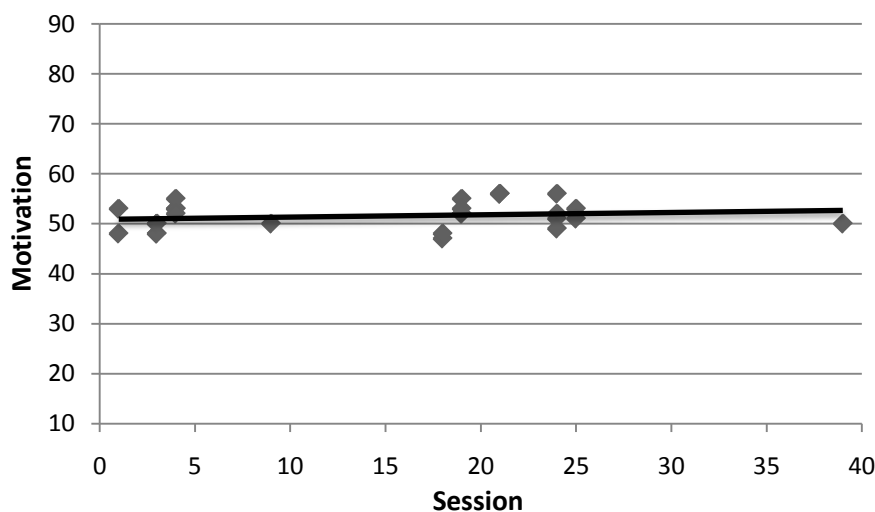
Showing elevated Insight and recognition of a defensive pattern developing through childhood, he describes, “I have always been told that I do not get angry” (19). He adds that he was not taken seriously when he expressed anger and describes how he was laughed at by his parents when raising his voice.

He interpreted it as “not having had the permission to get angry”. “I had the understanding of having to be quiet and calm. I never got an opportunity to not be like that”. He also describes his parents as models that were avoidant of confrontation and depict situations where his parents failed standing up against other family members, saying, “There were never any discussions, never arguing, always easy and quiet. Conflict was pretty unknown to me” (20). He also describes that his father worked as a “slave” without resistance at his job and had exaggerated respect for authoritarian people like employers and teachers. The patient suggests that maybe these developmental experiences are where his uncertainty and compliance was founded, “By modeling and experience”. The patient attributes also possible causes of maladaptive patterns of inhibiting anger to his background with older friends (6), where he felt small and powerless saying “I was defensive with dominant pals” (38) and describes that he was forced to do activities because they ordered him to do so.

There is one instance of good Insight into maladaptive behavior (71) where he links, in a more detailed way, his past experiences of being quiet to the present situation at work where he has trouble standing up for himself and expressing anger.

### **Motivation (relinquishing of defenses)**

The level of Motivation to change range between 47 and 56 on the ATOS indicating low-moderate to moderate motivation to change (figure 10). This level of Motivation represents moderate wish to change with moderate discomfort over costs of maladaptive behavior, but also moderate resistance. The level of Motivation to change is very stable and there is no significant change scored across therapy (table 5).



*Figure 10: Shows ratings of Motivation to change maladaptive pattern of anger/assertion phobia through therapy.*

#### ***Quantitative descriptions of Motivation to change affect phobia against anger/assertion***

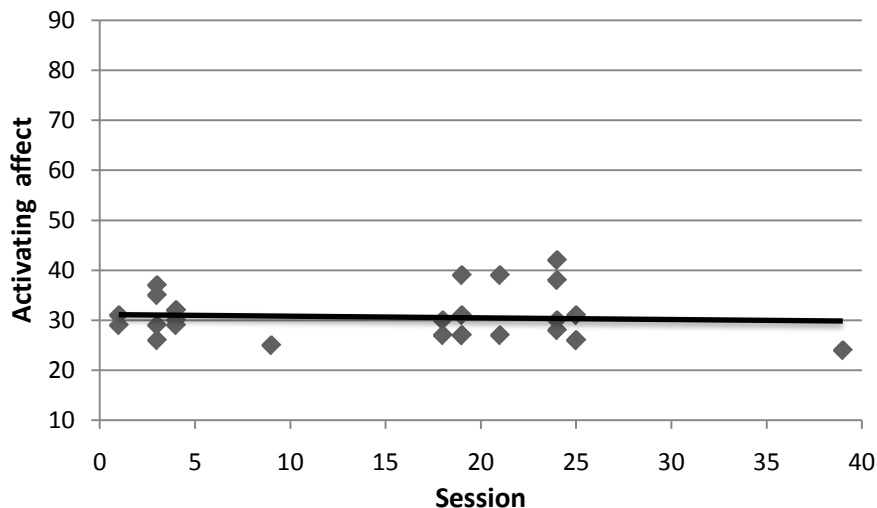
Examples of the general moderate level of Motivation is that he says that he is uncomfortable with holding back anger, linking this to hopelessness, indicating discomfort over costs of maladaptive behavior. The patient agrees with the therapist that he needs to work with his anger and that he might benefit from expressing anger saying, “I surely would be best off letting my anger out”(4).

Examples of elevated Motivation is rated as the patient says that he wishes he could “let off some steam” (19), and wonders if it is “possible to do some training to be able to do that”. He also expresses hoping to change as he says, “I know it is possible to stand up against those who are dominating, I have seen it!” (38).

Signs of ambivalence and resistance to change can be exemplified as he describes the maladaptive behavior pattern in an ego-syntonic way, saying, “I am calm by nature, I take things easy” (18). He also expresses low motivation to change as he says, “I feel small and it is going to pass anyway”. He also expresses some satisfaction with status quo saying, “Despite dissatisfaction, I can appreciate my job because it feels safe in a way that I know what I get. I have accepted it in a way, settled down”, indicating low Motivation to change.

### **Activation affect Anger/assertion (affect restructuring, affect experiencing)**

The level of anger/assertion in therapy range between 24 and 42 on the ATOS (figure 11). Activating affect is rated at a very low level most of time through therapy and there are only a few segments of elevated anger/assertion, indicating low- to low-moderate level of affective arousal. In spite of incidents of elevated affect, the regression line does not indicate a significant change in level of Activating affect during therapy (table 5).



*Figure 11: Shows activation of anger/assertion through therapy.*

### ***Qualitative descriptions of anger/assertion***

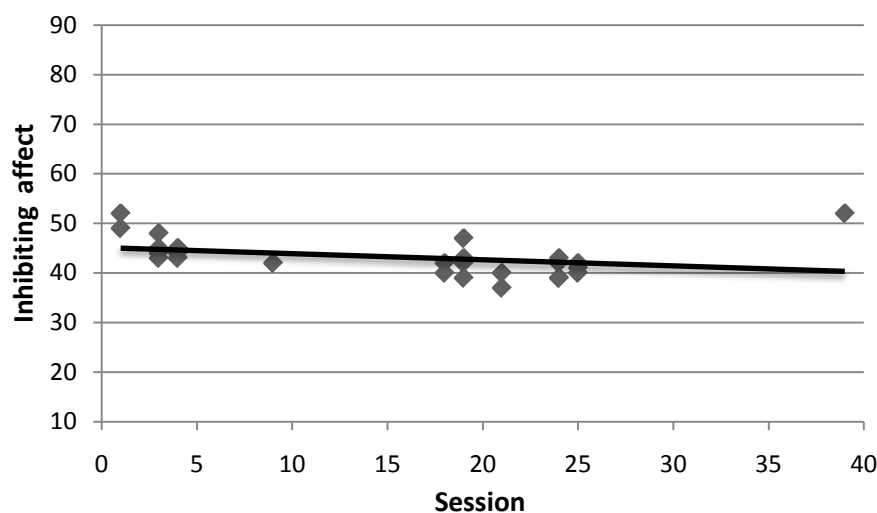
The generally very low levels of activating arousal of anger/assertion in therapy are characterized by elaboration on the core issue of anger/assertion with few indications of affect experience.

Some examples of elevated anger/assertion are noted. Slight indications of assertion are shown when he says that he felt overrun in a previous session where he wanted to talk about something else (3). In another session when the patient talks about an episode of submissiveness in his workplace, the therapist asks him what kind of feelings this evokes. The patient mentions irritation and eventually anger (18). He says “it may be anger that builds up, but it does not come out. I put a lid on it, I get numb”. The level of arousal observed is in the low category, indicating barely visible signs of feeling shown in face, vocal tone or body when imagining the situation. In the subsequent session, (19) the patients refer to another episode at work where he felt run over and unjustly treated.

He explains, with an upset tone of voice, how he experienced the episode and says forcefully and loud that he, “feels like shit!” and “like a kid who must stand up straight for the adults!” looking angry. Later in therapy (24) the patient describes another situation at work where he had felt anger towards the colleague he feels cowed and mistreated by. He describes that he had slammed the door to his office in an outburst of anger. The therapist tries to keep the patient in the emotional state evoked in the situation and encourage him to imagine the scenario and describe what he would have wanted to do. The patient expresses signs of anger by saying he “wanted to throw something at the wall”. The therapist explores what he would have thrown at the wall, and the patient says, “I wanted to tell X to go to hell! I wanted to throw X at the wall”. This episode is rated as the highest activation of anger in therapy.

### **Inhibiting affect (affect restructuring)**

The ratings are in the low to moderate level on the ATOS across therapy, ranging between 37 and 52 points on the ATOS (figure 12). The regression line indicates a tendency of decrease in Inhibitory affect as therapy progress (not statistically significant) (table 5).



*Figure 12:* Shows the rating of Inhibiting affects in segments of affect phobia against anger/assertion through therapy.

### ***Qualitative descriptions of Inhibitory affects in segments of affect phobia against anger/assertion***

The moderate level of Inhibitory affect is observed as the patient seems moderately tense and fearful in sessions focusing on anger/assertion phobia. The patient explains how anxious he is in situations that calls for anger at work where he feels over-run.

He says he is “paralyzed by a kind of fear, paralyzed and gagged” (25). Trying to explain the fear, he says, “I must be on my guard all the time”. In other sessions the patient report feelings of “numbness” as he struggles to express anger. A feeling of “anxiety that blocks the thoughts” is mentioned in situations outside therapy. The level of Inhibitory affect in sessions is in the beginning of therapy scored in the moderate area, and there seems to be a slight tendency of decreasing Inhibition related to anger/assertion phobia across therapy. Lower levels of Inhibition are scored in sessions when anger/assertion is elevated.

Table 5: Descriptives and regression coefficients for the process variables across therapy regarding affect phobia against anger/assertion

<i>ATOS variables</i>	<i>St. deviation</i>	<i>Mean</i>	<i>Adjusted R square</i>	<i>B</i>	<i>SE</i>	<i>t</i>
Insight	5.8	53.5	-.04	.03	.110	0.30
Motivation	2.7	51.5	.04	.05	.050	1.06
Activating affect	4.8	30.6	-.04	-.03	.092	-0.32
Inhibiting affect	3.8	43.2	-.08	-.12	.068	-1.76

\*p< 0.05. \*\*p< 0.01.

### **Summary: Treatment of affect phobia against anger/assertion**

The patient shows insight into the maladaptive pattern of avoiding anger/assertion expression because of fear of receiving escalating critique and being yelled at back. He elaborates on possible developmental causes of this pattern by linking connections to the past where he experienced to be “accepted as a silent boy” and modeled submissive parents. The patient’s motivation to change indicates some willingness, but also ambivalence as he expresses hopelessness and stagnation in the defensive patterns. The general level of anger/assertion is in the very-low to low area. There are some events of elevated anger and assertion in therapy. The highest level of Activating affect is when the patient imagines a sequence from work with the dominant colleague where he would have wished to stand up for himself and expressed anger. The Inhibitory affect is in the moderate level and show a slight tendency (not significant) to decrease in segments of elevated anger. The levels of Insight, Motivation and Activating affect show no significant change during the course of therapy (table 5).

### Summary of the process variables of all three affect phobias rated across therapy

The ATOS results indicate relatively stable Insight scores at a moderate level, except for the affect phobia of grief/sorrow which indicate a low-moderate level, but also show a slight increase across therapy. A stable low-moderate level of Motivation is scored across therapy for all affect phobias, the Motivation for affect phobia against grief was slightly lower. A generally very low level of Activating affect with a few examples of elevated activating affect are rated for all affect phobias, indicating no significant increase across therapy. The level of Inhibitory affect regarding phobia of anger/assertion show the lowest mean level and a decreasing tendency (not significant). Regarding phobia of positive feelings for self and grief/sorrow are the Inhibitory affect in the low–moderate level and increases in later sessions to a moderate level.

### 3.3 Predicted in–session sequential relationships between the process variables

Table 6: ARIMA cross–correlations between process variables residuals in-session at different lags.

<i>First variable second variable</i>	<i>Lag</i>				
	+2	+1	0	-1	-2
Insight – Motivation	-.01	-.07	.21**	.02	.07
Motivation – Activation	.02	.00	.31**	-.05	-.07
Activation – Inhibition	.04	-.04	.15*	-.07	-.04

Note. +2 = First variable leads second variable with 2 lags (2 segments); +1 = first variable leads second variable with 1 lag (1 segment); 0 = same time correlation; -1 = second variable leads first variable with 1 lag (1 segment); -2 = second variable leads first variable with 2 lags (2 segments).

\*p<.05. \*\*p<.001

As table 6 indicates, none of the predicted relationships were found by the ARIMA analyses. Conducting exploratory ARIMA analyses, investigating all potential relationships between residuals of the process variables, a sequential relationship ( $r = 0.11$ ,  $p < .05$ ) between Insight (lag 0) and Activating affect (lag 1) was found (not in table). This indicates that Insight predicted Activating affect in the next segment. The ARIMA results show, on the other hand, small to moderate, same time correlations (lag 0) between the process variables.

The results indicate no temporal relationships between the predicted variables, but that the variables seemed to co-vary somewhat at the same time (same segment) (Table 6).



## 4 Discussion

The purpose of the present study was to investigate the level and change in four process variables predicted by APT to be essential in psychological treatment, examining a patient with Cluster C personality disorder who has received forty sessions of APT.

The findings of this study will be discussed in the subsequent sections in relation to the outlined research questions from the introductory section.

### 4.1 Affect phobias in therapy

The main affect phobias focused on during the course of the therapy, were “positive feelings for self”, “grief/sorrow”, and “anger/assertion”.

The patient described strong feelings of inferiority and had trouble uttering his own wishes and needs. As such, the affect phobia of positive feelings for self was the predominant focus rated through the course of therapy. The low level of “positive feelings for self” was observed as lack of belief in his own worth, own capacities and general insecurity in his own choices.

The second most rated affect phobia, was grief/sorrow related to the divorce the patient was going through and earlier losses. The patient seemed to be able to both elaborate on and express grief in relation to his earlier losses. However, the exploration of feelings in relation to the recent divorce seemed to trigger avoidant, “phobic”, reactions. The patient said several times explicitly that he did not want to elaborate on these feelings and expressed a fear of touching on these feelings e.g., “I don’t know what will happen if I approach the bad feelings” and, “I’m afraid of it, afraid they will take the upper hand”.

An implication from these observations may be that an affect phobia is not necessarily general across situations and relations, but may be more specific and situation-dependent. Greenberg (2008) notes that feelings should be treated specifically, concerning with whom they are evoked, in what occasions, during what conditions etc. The ratings and observations done in this study seem to be somewhat in line with that notion.

The third most prominent affect phobia was anger/assertion. The patient expressed uncertainty about his rights to set limits and was reluctant to express anger. The patient’s maladaptive pattern of suppressing or in other ways holding back anger was explored in

relation to a colleague he felt submissive towards. He described feelings of numbness in situations that called for anger. During therapy he was able to get in touch with these feelings and in some way elaborate on them.

## **4.2 Predicted between-session change in the process variables across therapy**

The APT predicts increase in the process variables of Insight, Motivation and Activating affect, and decrease in Inhibitory affect, enabling restructuring of defense and affect phobia. Only for Insight regarding the affect phobia of grief/sorrow the predicted increase was found. Contrary to our expectations, Inhibitory affect increased across therapy for the affect phobias of positive feelings for self and grief/sorrow. Only a modest tendency of decrease was found in the Inhibitory affect variable regarding the affect phobia of anger/assertion.

According to APT the main mechanism of change is exposure of phobic affect in a new relational environment with corrective emotional experience, leading to habituation and new learning. Successful therapy would thus predict an increase in Activating affect across therapy as affect phobias are restructured and higher tolerance for affect is gained, showing a decrease in Inhibitory affects. The manual for APT (McCullough et al., 2003) does not indicate a specific level of intensity or duration of affect needed to effect change. McCullough (1997) does however delineate some descriptions of activating affect indicating an adaptive level of exposure depicted as a “surge and flow” or “resonating of some form of energy that generates an action tendency”. The affect should also be followed by a “sense of relief” and “mild-to-moderately felt experience is often sufficient for change to occur” (p. 227). This description implies at least low-to moderate affective arousal of activating affect, or around 40 and above on the ATOS. According to this, the levels and changes in the process variables observed in this study would indicate a suboptimal treatment with little desensitization of any of the phobic affects.

This “suboptimal” change in process variables may be illuminated by the therapist-patient interaction observed during the course of therapy. According to McCullough et al. (2003), APT is a therapy where the patient is active and engaged and the therapist maintains goal-directed towards the focus of the treatment. The reason for this is being as efficient as possible and not “teaming up” with the patient’s defenses. As illustrated in the results section,

the patient did show a great deal of reluctance to approach the emotions and be “exposed” to feelings, especially grief/sorrow related to his divorce. In session three, the patient was angry with the therapist for setting the agenda and talking about the patient’s divorce in the previous session. After this episode, the therapist seemed to be somewhat more reluctant to pushing the patient into the phobic feelings and setting the agenda. The subsequent sessions often started with the therapist asking, “What `s on your mind today?”. The patient then decided what themes to discuss and elaborate on.

On the other hand, the therapist did have an ongoing focus on the patient’s feelings and defenses, and tried to guide the patient’s consciousness towards his emotional experiences and affects. There were in later sessions several incidents where the therapist tried to “gently push” the patient in the direction of avoided feelings, especially grief/sorrow. The patient’s reaction to this was often explicit resistance, e.g. by changing the subject, or sometimes even irritation. In line with these descriptions, there were generally low levels of Motivation rated across therapy, especially regarding the affect phobia against grief/sorrow. The fact that the therapist let the patient set the agenda may have been crucial to maintain a good working alliance. It is possible that the therapist knowingly tried to push the patient into experiencing avoided affects, and at the same time tried to regulate the patient’s level of distress by letting him set the agenda, to maintain a good working alliance. Still, one might speculate that the therapist’s reluctance to challenge the patient’s avoidance strategies may have hindered effective change work on the process variables.

The low scores on Motivation and the suboptimal changes in the process variables may be understood based on partly overlapping concepts, associated with the working alliance, including the patient’s role engagement, suitability for treatment and openness versus defensiveness, all assumed to be essential for goal attainment and positive outcome of psychotherapy (Orlinsky et al., 2004). The link between therapeutic alliance and outcome is widely recognized (e.g., Horvath & Symonds, 1991) and the alliance has been proposed to be a prerequisite to produce emotional processing in therapy (Horvath, 2005). The therapist’s “flexible” behavior may be understood as an effort to maintain a good therapeutic collaboration and the low levels of Motivation scored throughout the treatment may illuminate the suboptimal changes in the other process variables.

### **4.3 Predicted in-session sequential relationships between the process variables**

The ARIMA analysis did not confirm any of the specifically predicted sequential relationships between Insight and Motivation, Motivation and Activating affect or Activating affect and Inhibiting affects within sessions. These findings indicate that the assumed relationships did not exist in this case, and are in line with the absence of predicted change between sessions across therapy. The findings may also illuminate the suboptimal change at treatment termination. Other possible explanations for the absence of predicted in-session relationships may be lack of sensitivity in the measurement, e.g. that any systematic variance in the process variables were too small to be detected by the ARIMA analysis. Another potential explanation is that the time interval of the segments (ten minutes) were inappropriate, either too short or too long. On the other hand, the results did show that Insight in one segment predicted Activating affect in the next. This finding is consistent with earlier studies of the role of insight in facilitating emotional elaboration (Milbrath et al., 1999). However, we did not find the opposite relationship, that the experience of Activating affect predicted Insight, a relation that is proposed by other theorists (e.g. Greenberg & Malcom, 2002).

The same time correlation found between the process variables indicate that they, at least to some degree, did co-vary within the same segment (same Lag). The correlations between the residuals of Insight-Motivation, Motivation-Activating affect and Activating affect-Inhibiting affect, indicated small to moderate correlations ( $r = .21$ ,  $r = .31$  and  $r = .15$  respectively). This finding concurs with the qualitative observations of the therapy process. The association between Insight and Motivation in the same segment did seem to co-vary, e.g. when the patient's lower scores of Insight were rated regarding grief/sorrow reactions in relation to the divorce (e.g., trying to find physiological explanations to his distress), low scores on motivation to change were rated (e.g., actively avoiding the subject of feelings related to the divorce). The association between Motivation and Activating affect does also resonate well with the overall clinical impression (e.g., when Motivation to explore feelings of grief/sorrow was low, a low level of Activating affect typically was observed in the same segments). The correlation between Activating affect and Inhibiting affect is also in line with the clinical impression (e.g., increased levels of Activating arousal was present when heightened levels of Inhibitory affect was present).

The same time correlations indicate that the process variables are somewhat associated. The relatively small and moderate size of the correlations may indicate that they also work as separate variables, and probably represent different aspects or factors within the therapeutic process.

Because no temporal relationship between the variables were found, we cannot implicate the direction of the potential relationships, or exclude the possibility of other unmeasured variables to have effect on all the correlated variables.

In light of the ATOS ratings and the predicted APT theory of change, the therapy did not seem to have much effect neither across therapy, nor within sessions, as none of the predicted process changes were observed during the course of the therapy.

#### **4.4 Did the patient change? -Understanding the general outcome measures of the treatment**

The outcome measures paint a mixed picture and it is unclear to what degree the patient has benefited from the treatment. Judging the therapy as successful or not, depends on what measures one focuses on and on what time interval one examines after therapy. Clinically significant change deals with return to normal functioning and can be defined as when a patient moves from a dysfunctional population to a functional or normal population, and the magnitude of the patient's change is statistically reliable (Jacobson, Roberts, Berns & McGlinchey, 1999). The relatively low pre treatment-score on the GSI (0.82 vs 1.15 as the sample mean) may have reduced the probability of gaining a clinically significant change for the patient. A significant change on the GSI (RC; Jacobson & Truax, 1991) would in this case require a score at termination almost one standard deviation below the average of the normal reference sample, a hard criterion to fulfill. Still, the reduction on the GSI of 0.46 from the beginning of the treatment to termination is indicative of a certain level of change in symptom distress. The two-year follow-up scores show even further decrease in symptoms indicating a highly unsymptomatic status on the GSI.

The IIP-Global scores were in the dysfunctional/pathological range both before treatment and at termination, indicating a suboptimal therapeutic change. However, it moved into the range of the normal population at two-year follow-up.

MCMI-III showed no significant decrease in reported scores at the end of therapy. The patient's pre- treatment scores were again low compared to the treatment group in general (mean = 54 vs 64.2) and was even at intake below cut-off for belonging to the clinical population. He was by definition in the normal population, or in remission, the whole way on this measure. Two-year follow-up scores indicate even lower levels of personality problems reported.

In sum, the outcome measures indicate a general symptom reduction at the end of treatment, reduced personality- and interpersonal problems at two years follow up, and further decreases in symptom distress.

## **4.5 How do the observed process variables of the ATOS relate to the general outcome of the treatment course?**

In the subsequent sections the ATOS scores and APT's proposed mechanisms of therapeutic change and their relationship with general outcome will be discussed. Qualitative excerpt from the therapeutic dialogue will be used to illustrate the process and potential mechanisms of change.

### **4.5.1 Outcome at termination**

Assuming that the therapy did indeed have some positive effects on the patient's symptom distress at treatment termination, it is not indicated from this study that the mechanisms of change was the APT's principles of graded exposure and desensitization of phobic affects. On the other hand, it is not possible to exclude the potential therapeutic effect of the occurring exposures of Activating affect, even though they were relatively scattered and few in number.

According to Davanloo (1990) it is important for patients to become aware of and experience feelings to enable the "working through" of unresolved feelings related to broken attachments in the past and other trauma. Indicating that a few examples of "breaking through" is therapeutic, it may be that the episodes of emotional arousal in the therapeutic relationship had significant effects on the patient, even though no systematic changes in the relevant variables could be detected either within or across sessions.

It is possible, the few episodes of fairly low level experience of emotional Activation enabled facilitation of essential emotional restructuring, leading to changes in the patient. Though, not through the process of systematic habituation and desensitization, it may be that the affective incidents made the patient relate differently to himself and/or others thereafter.

Although the emotional arousal was generally low during therapy, the therapist did seem to have a continuous focus on the patient's affects and how he related to them. Emotion-focused theorists have proposed that there are aspects of the therapeutic process, other than emotional activation and arousal that are essential to emotional restructuring. "Personal reflection" (Monsen & Monsen, 1992) and "emotional processing" (Greenberg, 2008), including reorganization of affective scripts and connecting cognitive-affective experiences respectively, has been announced as an essential part of therapeutic healing process.

Monsen and Monsen (1992) stresses the aspect of reflecting on affective material to facilitate affect consciousness. The level of affect consciousness, defined as the individuals capacity to be aware of, tolerate and express, verbally and non- verbally, emotional states, has been linked to psychopathology. Increased affect consciousness has predicted positive outcome in patients with severe personality disorders (Monsen, Odland, Daae & Eilertsen, 1995) and chronic pain conditions (Monsen & Monsen, 2000). The theory predicts that increased affect consciousness, through emotional integration and reorganization of maladaptive affective scripts, enables patients to make use of the affects as signals and motivating agents in new and more adaptive ways (Monsen & Monsen, 1992).

Greenberg (2008) notes, that in addition to facilitating emotional activation, integration of affective experience with cognitive elaboration is important for positive therapeutic effects. Increased awareness of, and reflection on emotional content is also essential in Greenberg's theory of therapeutic change. The theory stresses that this emotional processing is most efficient when affects are at an "optimal level" (not too much, not too little) and that moderate amounts of emotional arousal best predict good outcome (Carryer & Greenberg, 2010).

One may speculate whether the "personal reflection" or "emotional processing" in therapy was of significant value to the patient in this study. Despite the relatively low levels of Activating affect across the therapy course, there seemed to be an ongoing focus on affects through therapy. It is possible that this contributed to the patient's symptom reduction and may illuminate the lowered distress level at termination.

Another element of the therapeutic process is the aspect of insight. Even though the Insight scores for the affect phobias against positive feelings for self and anger/assertion did not increase during therapy, the ATOS data did show greater variance in Insight scores later in therapy than in earlier sessions. The highest Insight scores rated were in the second half of the treatment for all the affect phobias. This may indicate an increased capacity to reflect on psychological content connected to the affect phobias as therapy progressed. For example when the therapist asked the patient at the end of therapy what he had learned from the process, the patient said, “first and foremost I have gained insight into the problems and the needs I have” (40). He added, “I understand the connections and what I am struggling with, what I am afraid of”, and, “In the beginning I did not feel that what we talked about had anything to do with the problems I had”. Further he said, “I see in retrospect that things are connected, that things repeat themselves even at work, at home and with others” and, “I see now that it is not the job per se that is the problem, but other stuff. I have learned other ways to handle things”. He says further, “I think this knowledge is of good help”.

The patient’s words at the end of therapy indicate that he had gained insight into his own feelings, needs and ways of avoiding affect. This may indicate a form of emotional insight where he connects emotional experiences with new meaning. He shows an ability to see links between how things are connected and indicates a change in the way he understands himself in relation to others. These statements are in line with Hill et al’s., (2007) definition of insight as a “conscious meaning shift involving new connections”. Accordingly, it is possible that the patient gained increased insight from therapy and attained a broadened repertoire of handling different real-life situations.

This “accumulated” gain in insight, however, was not captured by the ATOS ratings. These findings can be understood in light of a distinction between Insight as a process variable, and insight as an achievement in itself. Accumulated insight can be understood as a typical characteristic of earlier psychoanalytic writings where attainment of insight is seen as a super ordinate goal of therapy (Messer & McWilliams, 2007). The ATOS defines and conceptualizes Insight as a process measure, as means to defense-, and affect restructuring, and does not necessarily capture the kind of accumulated insight described by other theorists.

Other concepts, partly overlapping with insight, are aspects of “reflective functions”. The sustained focus on emotion and meaning may have facilitated better reflective functions in the patient. The basic idea that clients build a capacity to reflect on their own affective and lived



experience, including keeping connections with that experience, and thereby developing insights on their own, has been proposed by different theorists to be a effective ingredient in therapy and is retained by patients long after therapy has been completed (Schottenbauer, Glass & Arnkoff, 2007). E.g., self-reflexivity (Aron, 2000), mentalization or reflective functioning (e.g. Fonagy, Gergely, Jurist & Target, 2002) and self-analysis, have all been shown to have positive associations with outcome after therapy and predict adjustment on a day-to-day level and to be retained by patients long after therapy has been completed (e.g., Krantowitz, Katz & Paolitto, 1990). Furthermore, level of self-understanding has been shown to be a common mechanism of change across Cognitive-Behavioral and dynamic therapies, and has been associated with symptom reduction across Axis I and Axis II disorders (Connolly Gibbons et al., 2009).

In line with the observations of the patient in this study, understanding of repetitive maladaptive patterns contributing to symptomatology has, been found to change more in dynamic therapies than in other treatment modalities (Messer & Warren, 1995). The patient's statements at the end of therapy may point to an increased ability to reflect on own experiences and indicate increased reflective functions, which may have facilitated the patient's symptom reduction at treatment termination.

Though there are certain indications that the patient gained increased knowledge about himself, conceptually and emotionally, this was not reflected by the ATOS scores. Still, the lacks of change on the IIP-Global and MCMI-III at treatment termination are consistent with the "sub-optimal" ATOS scores. One possible interpretation would be that the sub-optimal change on the ATOS reflects an essentially ineffective therapeutic process, and that the changes in symptom distress are a random deviation from the patient's normal level of functioning, while the lack of change on the IIP-Global and MCM-III more accurately reflects the therapeutic process. On the other hand, it is altogether possible that the processes depicted by the ATOS system are more relevant for understanding changes in more stable and personality related aspects of the patient's functioning, such as those presumably reflected at least partly in the IIP-Global and mostly in the MCMI-III.

Thus, it might be that the ATOS is not sensitive to the therapeutic processes necessary to effect change in levels of symptom distress, but do reflect changes in processes necessary to generate character change. As we have seen, the outcome data at the end of treatment did

indicate a suboptimal change in interpersonal and personality functioning, which is consistent with the APT predictions as the therapy contained only few exposures of affect phobias.

#### **4.5.2 Outcome at two year–follow up**

The outcome data at two-year follow–up indicate a further decrease in reported symptoms (clinically significant when compared with baseline) and clinically significant change on both IIP- and MCMI–III scores. It is unknown what caused the changes indicated by the two year follow–up measures, but we might speculate on some possible explanations.

Howard, Lueger, Maling and Marinovich (1993) notes, in line with the findings in this study, that changes in interpersonal and personality functioning are slower to occur than changes in subjective well-being and symptom distress. Howards phase model describes three phases of the psychotherapeutic process. The first phase is *remoralisation*, where the patient is assumed to experience increased hope for change. Howard et al propose that this mobilizes the patient's own resources in a good working alliance with the therapist, which is followed by reduction in experienced distress. The remoralisation phase includes that the patient is capable of perceiving the causes of his distress as stemming at least partly from internal, psychological reasons rather than external ones. In this study the patient came into therapy with a conceptual understanding of his distress as at least partly, stemming from external, job related causes, with vague descriptions of his own contribution to the problems.

The second phase proposed by Howard et al is *remediation*, including resolution of the patient's symptoms by promoting adaptive understanding of the problems and facilitating the patients coping skills etc. Later in therapy the patient seemed to get more and more in contact with his own feelings and needs, and understood how this was related to his problems of asserting his needs and have confidence in himself. This was indicated by somewhat higher scores on the Insight measure rated later in therapy.

The third phase proposed by Howard et al is *rehabilitation*. This phase includes more enduring changes, such as unlearning of longstanding and maladaptive patterns and establishment of new ways of dealing with various aspects of the self and life.

Progression through these different stages of change has received empirically support in several studies (e.g. Lutz, Lowry, Kopta, Einstein & Howard, 2001), but the speed and progression through the different phases vary and depend on several individual factors, e.g.,

the type and severity of pathology, the accessibility of the maladaptive pattern and impact of specific events in the patients lives (Barkham, Stiles & Shapiro, 1993). The assumed decrease in reported symptoms before change in social relationships and personality traits is hypothesized to be because of the needed translation of therapeutic benefits into different areas of life. The transference of the acquired knowledge requires expanding and development of adaptive cognitive, affective and behavioral changes, which often takes more time than symptom reduction (Howard et al. 1993). A critical question is thus in what way the patient was able to translate the accumulated knowledge (assumably) gained in this therapy to his real life.

In the last session, the topic of discussion was ending therapy as the patient said, “I will try to ask myself the questions I think that you would have asked after ending therapy”. The patient was at the time of therapy going through big changes in his private life as he divorced his wife and one of his children moved out. It is likely that the adaptation to this may have had a great impact in the patient’s personal and social life and it is possible that the potential positive adjustment to this affected the outcome scores at follow-up.

In the last couple of sessions the patient also talked about changes at work. He described that the colleague he had been feeling submissive towards was quitting. It is possible that this also may have had a significant impact on the patient’s life and may have affected the reporting on the follow-up measures.

The patient was concerned with finding his own way of working with his grief/sorrow and said in the ending session that he was motivated to give himself time and room to elaborate on what he had learned in therapy and “find my way on my own”. The increase in Inhibitory affect in the same session can be illustrated by the following statement: “I am afraid of getting the feeling of being where I was in the beginning, that I cannot use the knowledge I have learned”. He said that “I`m looking forward to it (ending therapy) but dread it. I dread if something unpleasant should come up without having this contact”. He said, “If anxiety gets too high, I am afraid it overshadows the knowledge I have gotten” and added, “On the other hand, I know that I often worry in advance, and that I afterwards often see that it went fine”.

An increased understanding of a problem does not necessarily mean taking the required steps for adaptive change. A potential pitfall of “understanding” may be increased defensive behavior, such as intellectualization, rationalization or other coping strategies, leading to

sustained avoidance of affect experience and expression. The two year follow-up measures indicated that the patient adapted well to his new life and the results are in line with other studies which have indicated that interpersonal styles and personality traits are more robust than states and have been reported to change more slowly than symptom relief (Kopta, Howard, Lowry & Beutler, 1994). If these changes at follow-up can be attributed, at least in part, to the treatment course, it would seem that the process variables in the ATOS and their postulated interconnections were not able to detect and represent the source of those positive developments after ended therapy.

## **4.6 Limitations**

The use of single case design enables studying one therapeutic process in detail, but has essential limitations regarding external validity. The findings in this study may be unique to the patient studied, and somewhat other processes could be expected with other patients. As mentioned, change in the outcome measures can be attributed to other external variables outside therapy, and the study does not control for this. The ATOS rates patient behavior proposed by APT to be essential in therapy. The design does not differentiate between patient effects, therapist effects, or interaction effects of these, and can thus not exclude such factors.

It is important to mention that this study examined the three most occurring affect phobias rated in therapy. There was during the course of therapy some segments ( $n = 14$ ) coded as “other” which are not examined and the relevance of these to the therapeutic process is unknown.

The documentation of the ATOS validity is limited, so the results should be treated with precaution. As proposed in the discussion section the construct validity of the variable Insight as it is used in this study may be threatened as it is narrowed down to measure specific aspects of defensive behavior and does possibly not capture the more wide ranging cognitive-affective meaning shifts proposed by Hill et al. (2007). Another point to be made regarding the process variables measured, is that they measure observable behavior as witnessed by external raters. E.g., the patient’s expressed insight in sessions is rated, which does not necessarily fairly measure the “true” level of insight. The therapist does contribute with a lot of insightful material that the patient possibly absorbs, but this is not captured by the ATOS.

Another possible limitation is the measuring of affects in therapy. Emotional states are often complex blends of affect, shifting rapidly. The ATOS captures only the predominant Activating and Inhibiting affect per segment. Other less dominant affects are not rated and thus not accounted for. The rating of the process variables is done by observations of behavioral operationally defined concepts. E.g. the level of Activating affects assessed is based on observation of arousal, which can be a deficient measure of the patients actual inner felt emotion (Sparks & Greene, 1992). The different affects have different physiological and behavioral manifestations (Ekman, 1992) and some affects may be harder to observe and rate. E.g. high levels of positive feelings for self can, compared to anger, be hard to find as a highly aroused state. The same is evident for the Inhibiting affects. In this treatment anxiety was coded as the dominant inhibitory affect in 85% of the segments. It is possible that shame and guilt was present to a larger extent, but might have been overlooked, as their expression may be more subtle and harder to notice. On the other hand previous research has indicated that both general and specific aspects of emotional arousal can be reliably rated from observable behaviors (Burgoon, et al., 1993).

It is also important to note that there are several ways to estimate the temporal relationship between variables in time series analysis. ARIMA is an established and well-known method (Darlington & Smulders, 2001) and was thus a natural choice of method. The possibility that employing other methods might yield different results cannot be excluded.

Limitations regarding the qualitative aspects of this study should also be mentioned. As stated in the methods section, the quotes were selected based on their significance and ability to describe general/typical examples of the ATOS ratings, or illuminate deviations e.g., higher or lower than the typical/general scores. The potential of biased selections and “narrative smoothing” (Edwards, 1996) cannot be excluded. The reported findings should thus be interpreted with precaution as they only give a limited picture of the complete therapeutic processes.

The lack of statistical investigation of the relationship between the process variables and outcome in this study also limits the possibility of drawing conclusions about the relationship between ATOS-ratings and general outcome.

It also is impossible to exclude that other unmeasured variables have had effects on the delineated relationships. The findings thus allow us only to speculate in potential therapeutic mechanisms of change and assumptions proposed should be seen as tentative.

## **4.7 Conclusion**

The study of micro-processes within a single-case study design may give detailed and valuable information to the field of psychotherapy research and add unique knowledge in the quest for uncovering mechanisms of therapeutic change. The growing interest in emotions and their assumed centrality in psychological, social and physiological well-being has yielded positive results and consequently resulted in an increasing number of affect-focused therapies. This study examined specific variables proposed by Affect Phobia Therapy to be essential for therapeutic healing. Analyzing and interpreting quantitative measures from a complete therapy course revealed suboptimal change in the process variables of the ATOS indicative of a therapy with suboptimal outcome. In addition, analyses of the predicted sequential relationships between process measures did not show the expected associations. These findings are consistent with the suboptimal changes in interpersonal and personality functioning reported at treatment termination, but somewhat at odds with the development on symptom distress. The patient's symptom reduction may be seen in light of the ongoing emotion focus through therapy, but the influence of other unmeasured variables can not be excluded. The follow-up measures demonstrate reduced levels of symptoms, interpersonal problems and maladaptive personality traits, a change that can hardly can be accounted for by the ATOS ratings.

Other theories of therapeutic change are somewhat in line with the current findings of symptom reduction preceding deeper and more comprehensive change. The probability of few affect exposures leading to essential emotional restructuring have been proposed by other theorists and may account for the results found here. The long-term effect of repeated process learning with a sustained focus on affects and their associated meaning may have induced essential experiences in the patient's self-understanding and subsequent character change.

The design of this study does not allow any causality to be established, but the findings may shed light on a number of emotion-focused theories of therapeutic change.

Investigations of single cases in the future may benefit from studying patients with unmistakably positive or negative outcome, to get a clearer picture of the proposed mechanisms of therapeutic change. Single-case studies may add substantial knowledge about the mechanisms of change in psychotherapy and give basis to refine, extend, modify and qualify established theories. On the other hand, such studies are severely limited in their ability to make predictions about psychotherapeutic processes common across patients. Further investigations of the mechanisms of emotional restructuring, and the assumed underlying processes of change would also require systematic exploration in studies of larger samples.

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# Appendix

**ATOS – 1 Page Brief Overview**  
**ACHIEVEMENT OF THERAPEUTIC OBJECTIVES SCALE- 20 Point Brief Rating Guides 16APR09**  
**The Psychotherapy Research Program at HMS**  
**Leigh McCullough Ph.D., Director**

**CORE AFFECTIVE CONFLICT:** 1) Anger/Assertion\_\_\_\_ 2) Sadness/Grief\_\_\_\_ 3) Closeness/Tenderness/Love\_\_\_\_  
4) Positive Feelings for Self\_\_\_\_ 4.1) Self Compassion\_\_\_\_ 4.2) Self Interest\_\_\_\_ 4.3) Self Respect 4.4) Self  
Confidence/Mastery 4.5)Self Worth \_\_\_\_4.6) Self Entitlement/Deserving\_\_\_\_ 4.7) Other\_\_\_\_  
\_\_\_\_ 5) Sexual Feelings 6) Enjoyment \_\_\_\_ 7) Interest/Excitement \_\_\_\_  
8) Healthy Fear\_\_\_\_ 9) Other \_\_\_\_\_ 10) Unclear \_\_\_\_\_

**INSIGHT OR AWARENESS INTO MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS**

81-100-Excellent recognition of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.  
61-80--Good recognition of problem patterns. Some description of origins in past, linked to present. Good awareness/insight.  
41-60--Moderately clear recognition. On own describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.  
21-40--Low recognition. Can see problem pattern **only** when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.  
1-20--No recognition of maladaptive behavior patterns, or unsure when pointed out. May mention anxiety without reference to pattern. No awareness/insight or resists awareness/insight.

**MOTIVATION TO GIVE UP MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS**

81-100-Excellent motivation to give up maladaptive patterns. Very strong discomfort, sorrow, openness to change. Little/no resistance.  
61-80--Strong motivation to give up maladaptive patterns. Strong discomfort, sorrow, openness to change. Low resistance.  
41-60--Moderate motivation to give up maladaptive patterns. Moderate discomfort, sorrow, openness to change. Moderate resistance.  
21-40--Low motivation to give up maladaptive patterns. Low discomfort, sorrow, openness to change. Much resistance.  
1-20--No motivation to give up maladaptive patterns. Ego-syntonic/desirable. "This is who I am." Almost total resistance.

**ACTIVATING AFFECTS (VERBAL OR NONVERBAL BODILY SIGNS OF AROUSAL OF MAIN CONFLICTED/ PHOBIC AFFECTS)**

81-100-Full experience of emotion, well-integrated. Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.  
61-80--Strong experience of emotion. Strong affect quickly cut off or sustained but a little held back.  
41-60--Moderate experience of emotion. Some grief, some anger, some openness/tenderness/trust/care, etc. Some holding back.  
21-40--Low experience of emotion. Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc. Much holding back.  
1-20--Little/no physiological experience of emotion in facial expression, verbal report, tone of voice, body movement. Flat, dull, bland presentation.

**INHIBITORY AFFECTS: (VERBAL OR NONVERBAL BODILY SIGNS OF ANXIETY, GUILT, SHAME, OR PAIN**

81-100--Extreme inhibitory affect: e.g., extreme shakiness, hesitancy, vigilance, trembling, anxiety or shame. Extreme uneasiness.  
61-80--High inhibitory affect: e.g., high levels of shakiness, hesitancy, vigilance, trembling, anxiety or shame. Great uneasiness.  
41-60--Moderate inhibitory affect: e.g., moderate shakiness, hesitancy, vigilance, trembling, anxiety or shame. Moderate uneasiness.  
21-40--Low inhibitory affect: e.g., low shakiness, hesitancy, vigilance, trembling, anxiety or shame. Low level of uneasiness.  
1-20--Little or no inhibitory affect. Little or no shakiness, guardedness, hesitancy, vigilance, trembling, anxiety, etc. Comfortable, at ease.

**NEW EMOTIONAL LEARNING: ABILITY TO EXPRESS THOUGHTS, FEELINGS, WISHES, OR NEEDS**

81-100-Excellent expression of thoughts/feelings; sense of completeness, balance and excellent results. Great relief and satisfaction experienced.  
61-80--Good expression of thoughts/feelings; slight holding back. Not all expressed, but good sense of relief in speaking up. Good satisfaction.  
41-60--Moderate expression of thoughts or feelings; moderate holding back, but moderate effectiveness. Moderate relief. Moderate satisfaction.  
21-40--Beginning attempt to express thoughts or feelings. Much holding back. A little relief in expression. A little satisfaction.  
1-20--No expression of adaptive thoughts or feelings. Total holding back. No relief. No satisfaction. High end of this rating level: can begin to imagine expressing adaptive thoughts or feelings, wants and needs, but is as yet unable put it into action.

**SENSE OF SELF**

81-100-Highly adaptive sense of self; compassionate and accepting of strengths and vulnerabilities.  
61-80--Very adaptive sense of self; much compassion and acceptance, but some self-blame or shame present.  
41-60--Moderately adaptive/maladaptive aspects of self-image in approximately equal amounts.  
21-40--Very maladaptive sense of self, but a little compassion, and a little ability for acceptance.  
1-20--Highly maladaptive sense of self; little or no compassion, awareness, or self acceptance—or excessive grandiosity.

**SENSE OF OTHERS**

81-100-Highly adaptive sense of others. Very much compassion/acceptance/trust in others; little or no idealization or devaluation.  
61-80--Very adaptive sense of others. Much compassion/acceptance/trust, but some devaluation or idealization.  
41-60--Moderately adaptive as well as maladaptive aspects; moderate compassion/acceptance/trust, moderate devaluation/idealization.  
21-40--Very maladaptive sense of others, but some compassion, empathy or ability for acceptance; much devaluation or idealization.  
1-20--Highly maladaptive sense of others; Little or no compassion, empathy or acceptance. Very much devaluation, idealization or splitting.

## INSIGHT

### Level of Insight, Understanding, or Awareness of Maladaptive Patterns 16APR09

STDP: Defense Recognition (Noting Patterns of Maladaptive Defenses, Anxieties, and Feelings) CBT: Recognition of Maladaptive Cognitions or Maladaptive Cognitive Schemas DBT: Mindfulness of self-destructive pattern. Degree of dialectical thinking/ behavior .

#### MAIN COMPONENTS:

1. Degree of clarity and fullness of **verbal** descriptions of maladaptive patterns of thoughts, feelings, and/or behaviors, with explicit examples.
2. Degree of ability to state why and how maladaptive/defensive patterns began and are maintained (secondary gain, meanings, causes, and with whom.).

NOTE: Rate higher within each 10-point category for multiple examples, and lower for fewer examples.

BRIEF OVERVIEW OF LEVEL OF INSIGHT or AWARENESS ABOUT MALADAPTIVE PATTERNS of THOUGHTS, FEELINGS and/or BEHAVIORS

**81-100 - Excellent recognition** of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.  
**61-80 - Good recognition** of problem patterns. Some description of origins in past, linked to present. Good awareness/insight.  
**41-60 - Moderately clear recognition.** **On own** describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.

**21-40 - Low recognition.** Can see problem pattern **only** when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.

**1-20 - No recognition** of maladaptive behavior patterns, or unsure when pointed out. May mention anxiety without reference to pattern. No awareness/insight or resists awareness/insight.

**91-100 Excellent recognition of maladaptive behavior patterns.** Clear, comprehensive descriptions of maladaptive patterns. Describes clearly and fully how pattern is transferred from past to present. (e.g.; learning history or T-C-P links). Also, excellent descriptions of reasons for maladaptive responses, including meanings and secondary gain. Excellent and full awareness/insight.

**81-90 Very good recognition of maladaptive behavior patterns.** Clear, somewhat detailed descriptions of maladaptive patterns. Very good description of origins in past, linked to present. Very good understanding of reasons for maladaptive responses, meanings and secondary gain—but not all aspects mentioned. Very good awareness/insight.

**71-80 Good recognition of maladaptive behavior patterns.** Good but not detailed descriptions of maladaptive patterns. Some description of origins in past, linked to present. Good understanding of reason for maladaptive responses or secondary gain. Good awareness/insight.

**61-70 High-moderate recognition of maladaptive behavior patterns.** Fairly good, descriptions or examples of maladaptive patterns. Minimal description of origins in past, or links to present. Some understanding of reasons for maladaptive responses or secondary gain. Fairly good awareness/insight.

**51-60 Moderate recognition of maladaptive behavior patterns.** Partial descriptions or examples of maladaptive patterns. No past-present links. No mention why maladaptive behaviors occur or secondary gain. Moderate awareness/insight.

**41-50 Low-moderate recognition of maladaptive behavior patterns.** **On own** begins to describe maladaptive patterns but only vague or general description without clear examples. No past-present links. No mention of why maladaptive behaviors occur nor understanding of secondary gain. Some awareness/insight.

**31-40 Low recognition of maladaptive behavior patterns.** Can acknowledge maladaptive patterns **only** when pointed out, but readily agrees when pointed out by therapist—with little elaboration. Lower level: Agrees without reluctance but does not elaborate further. Beginning awareness/insight.

**21-30 Minimal recognition of maladaptive behavior patterns.** Can acknowledge maladaptive behavior **only** when pointed out, but reluctantly agrees and does not elaborate further. Upper level: Agrees with a little reluctance. Lower level: Agrees with much reluctance/or unclear whether the patient agrees or not. The barest evidence of beginning awareness/insight.

**11-20 No recognition of maladaptive behavior patterns.** Does not recognize maladaptive patterns and questions, doubts or does not agree when pointed out by therapist. Seems to lack interest in identifying maladaptive patterns. No awareness/insight. Mention of anxiety or inhibition without understanding of maladaptive pattern is rated here.

**1-10 No awareness of maladaptive behavior patterns, anxieties or feelings.** Does not see maladaptive patterns on own nor when therapist points it out. Upper level: No apparent interest in recognizing maladaptive responses. Lower level: Disagrees or becomes angry/belligerent when maladaptive responses are pointed out. No awareness/insight or resists awareness/insight. No mention of anxiety or inhibition.



## MOTIVATION

### Level of Desire to Give Up Maladaptive Patterns 16APR09

STDP: Defense Relinquishing: Motivation to give up defensive patterns

CBT: Motivation to give up maladaptive cognitive schemas

DBT: Motivation to change maladaptive behaviors. Commitment

MAIN COMPONENTS: RATE the MODE over the 10 minute segment.

1. Degree of motivation to give up maladaptive patterns of thoughts, feelings, and/or behaviors.
2. Degree of dislike, undesirability or sorrow **specifically** about the costs of defenses or maladaptive behavior. (Base ratings on nonverbal or affective display of motivation; e.g. sorrow/sadness expressed about having the maladaptive behavior patterns.) NOTE: This is not quite the same as grief over losses of loved ones, which would be rated as Affect Experiencing if the focus of the segment is sadness.

NOTE: The lower the score, the greater the degree of overall resistance to change or the greater the defensiveness to warded-off feeling.

BRIEF OVERVIEW OF LEVEL OF MOTIVATION TO GIVE UP MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS

81-100 - **Excellent motivation** to give up maladaptive patterns. Very strong discomfort, sorrow, openness to change. Little/no resistance.  
61-80 - **Strong motivation** to give up maladaptive patterns. Strong discomfort, sorrow, openness to change. Low resistance.  
41-60 - **Moderate motivation** to give up maladaptive patterns. Moderate discomfort, sorrow, openness to change. Moderate resistance.  
21-40 - **Low motivation** to give up maladaptive patterns. Low discomfort, sorrow, openness to change. Much resistance.  
1-20 - **No motivation** to give up maladaptive patterns. Ego-syntonic/desirable. "This is who I am." Almost total resistance.

- 91-100 **Excellent motivation to give up maladaptive behavior.** Expresses (verbally and non-verbally) intense wish to change. Extreme discomfort over maladaptive behavior. Intense grief over costs of defenses. No resistance or defensiveness. Fully open to change.
- 81-90 **Very strong motivation to give up maladaptive behavior.** Expresses very strong wish to change. Very strong discomfort over maladaptive behavior. Very strong sadness over costs of defenses. Very little resistance or defensiveness. Very strong openness to change.
- 71-80 **Strong motivation to give up maladaptive behavior.** Expresses strong wish to change. Strong discomfort over maladaptive behavior. Strong sadness over costs of defenses. Low resistance or defensiveness. Strong openness to change.
- 61-70 **High moderate motivation to give up maladaptive behavior.** Expresses more-than-moderate wish to change. More-than-moderate discomfort over maladaptive behavior. More-than-moderate sadness over costs of defenses. Low-moderate resistance or defensiveness. More-than-moderate openness to change.
- 51-60 **Moderate motivation to give up maladaptive behavior.** Expresses moderate wish to change. Moderate discomfort over maladaptive behavior. Moderate sadness over costs of defenses. Moderate resistance or defensiveness. Moderate openness to change.
- 41-50 **Low-moderate motivation to give up maladaptive behavior.** Expresses some wish to change. Some discomfort over maladaptive behavior. Some sadness over costs of defenses. More-than-moderate resistance or defensiveness. Some openness to change.
- 31-40 **Low motivation to give up maladaptive behavior.** Agrees that change is needed, and that giving up the maladaptive behavior can be beneficial, but no discomfort reported about having the maladaptive behavior. Doubts own ability to change or fears change. Much resistance/defensiveness or ambivalence. Little openness to change.
- 21-30 **Very low or ambivalent motivation to give up maladaptive behavior.** Very low desire to change. Acknowledges maladaptive behavior as problematic, but also describes its benefits/secondary gain. Very much resistance, defensiveness or ambivalence. Very little openness to change.
- 11-20 **Barely evident motivation to give up maladaptive behavior.** Expresses almost no desire to change. Dislikes symptoms, but only acknowledges maladaptive behavior as mildly problematic, if at all. Fears expression of adaptive feeling or feels too hopeless to try. Strong resistance/defensiveness. Almost no openness to change.
- 1-10 **No motivation to give up maladaptive behavior.** Dislikes symptoms, but accepts, values or desires maladaptive behavior. (Fully desirable or ego-syntonic: e.g., "This is the way I am!"). Resists adaptive expression. Indifferent/masochistic attitude towards self. Almost total resistance or defensiveness. No openness to change.

## ACTIVATING AFFECTS

Level of In-Session Intensity/Depth/Fullness of Bodily Arousal to Phobic or Conflicted Affects 16APR09

STDP: Affect Experiencing: Degree of Bodily Arousal of Adaptive Affects (to desensitize Affect Phobias)

CBT: Affect arousal is not a primary focus – and may or may not be present

DBT: Mindfulness and management of internal reactions. Emotional modulation vs reactivity. Affect tolerance.

### MAIN COMPONENTS:

1. Intensity of arousal of **adaptive affect** (rate **peak** degree of arousal for anger, sadness, or excitement and the **deepest** arousal for joy, closeness, or self feelings). Base the rating on intensity of inner affective arousal as shown in vocal tone, facial expression, non-verbal behavior/movement or charged verbal statements. This is not a rating of intensity of interpersonal expression, which would be rated as Affect Expression/New Learning.
2. Duration of the affective arousal (a few seconds to many minutes).
3. Relief in the experience of the feeling.

NOTE: This scale does **not** a measure **inappropriate** or regressive affective arousal, which is defensive.

BRIEF OVERVIEW OF LEVEL OF INTENSITY OF ACTIVATING AFFECTS: IN-SESSION BODILY AROUSAL OF CONFLICTED/PHOBIC AFFECTS

**81-100 - Full experience** of emotion, well-integrated. Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.  
**61-80 - Strong experience** of emotion. Strong affect quickly cut off or sustained but a little held back.  
**41-60 - Moderate experience** of emotion. Some sadness, some anger, some openness/tenderness/trust/care, etc. Some holding back.  
**21-40 - Low experience** of emotion. Beginning indications of sadness, anger, openness/tenderness/trust/care/joy, etc. Much holding back.  
**1-20 - Little/no physiological experience** of emotion in facial expression, verbal report, tone of voice, body movement. Flat, dull, bland presentation.

- 91-100 Full and complete affective arousal.** Full and vivid feeling, imagery, and memories sustained over several minutes (ebbing and flowing); e.g. full sobbing, with other affects, e.g. murderous but justifiable outrage, openness/care/tenderness/joy/trust deeply felt as shown in face, vocal tone or body. Excellent ability to modulate or control affect, and integrate it with other affects that balance and enrich the experience, e.g. rage with compassion, tenderness with limit-setting. Full relief and resolution.
- 81-90 Very strong affective arousal.** Very strong feeling, imagery, and memories, well sustained (ebbing and flowing) just slightly inhibited or interrupted by other affects as shown in face, vocal tone or body. The affect is partially integrated with other affects, e.g. rage with some compassion; care/trust with limits. Very strong but not full relief.
- 71-80 Strong affective arousal.** Strong feeling either sustained (ebbing and flowing) with a little holding back or strong feeling that slowly diminishes or is interrupted by another affect; e.g., strong bursts of sobs or anger, strong expressions of caring/tenderness as shown in face, vocal tone or body. Minimal integration with other feelings. Imagery or memories with strong emotional content. Strong relief
- 61-70 High-moderate affective arousal.** Much feeling, somewhat sustained (ebbing and flowing) with some holding back or quickly cut off. e.g., bursts of crying or anger, much caring/tenderness/warmth/trust as shown in face, vocal tone or body. Only beginning indications of integration with other affects. Imagery or memories with much emotional content. Much relief.
- 51-60 Moderate affective arousal.** Moderate feeling; moderate duration/moderate holding back, e.g. tearing up, moderate anger, some tender feelings as shown in face/vocal tone/body. Imagery or memories with moderate emotional content. Moderate relief.
- 41-50 Low-moderate affective arousal.** Mild feeling with much holding back shown in face, vocal tone or body, e.g. briefly tears up, raises voice a little in anger, or says a few tender words for short duration, speaks openly. Imagery or memories with some emotional content. Some relief.
- 31-40 Low affective arousal.** Low, quickly passing experience of feeling shown in face, vocal tone or body; e.g. clenching fist, sighs, grimaces, choking up, slight sadness/anger/care for self but quickly stopped. Imagery or memories with low emotional content but appears very restrained/held back/constricted. Very little relief.
- 21-30 Very low affective arousal.** Minimal or barely visible/audible signs of feeling of short duration shown in face, vocal tone or body. May report slight change in internal bodily state. Imagery/memories have very low expression of feeling. Almost no relief.
- 11-20 No affective arousal, but bland verbal report of feeling.** Almost no expression on face. Flat/dull/bland tone of voice, stiff or barely moving body. Patient may sense a change in internal bodily state, but is unsure whether it is a feeling or not. Only bland, unfeeling report of images or memories with emotional content. No relief.
- 1-10 No affective arousal. No report of feeling.** No observable experience of feeling on face. Flat/dull/bland tone of voice. Stiff, unmoving body. No imagery or memories with emotional content. Emotionally numb and/or tense. Self hate/negation. No relief.

## INHIBITORY AFFECTS:

**Level of Anxiety, Guilt, Shame, Pain or other Inhibitory Affects 8/20/08**

**STDP:** Anxiety Regulation: The regulation of Inhibitory Affects (anxiety, guilt, shame, and pain)

**CBT:** Degree of Anxiety in the segment: Anxiety reduction is a primary focus. **DBT:** Degree of Anxiety/inhibition

**MAIN COMPONENTS:** Rate the degree of inhibition (the mode) in the 10-minute segment; i.e., the overall intensity of observable anxiety, guilt, shame, pain as shown in verbal report, vocal tone, and non-verbal behavior. Raters should pay attention to physiological signs of inhibition; Below is a non-exhaustive list of examples:

1. **Anxiety:** trembling, tension, squirming, shifting, restlessness, twitching, nail-biting.
2. **Shame or Guilt:** blushing, looking down, lowering tone of voice, hands over face or covering eyes, head down.
3. **Pain:** wincing, groaning, whimpering.
4. **Common to one or more of the above:** hesitation, looking away, shifting in seat, sweating, vigilance, guardedness. All kinds of displacement activities such as scratching, grooming, rubbing or twisting hair, rubbing hands, squirming or shifting in seat. (Under reconsideration...possibly defensive maneuvers.)

5. Also consider other Inhibitory affects such as contempt, disgust: curled lips, raised head looking down, or pulled away, nausea.

NOTE: It is very important to distinguish **inhibitory feeling** from **defensive behavior**, which is not coded on the ATOS scale. Confusion sometimes arises because people who are highly defended are often described as 'inhibited.' This scale codes **observable indications of inhibitory affect**. For example, a lowered head can **indicate** shame about sadness, and is coded. Defenses, on the other hand, are used to avoid or escape from inhibitory affects, and hence lead to a reduction in inhibitory affect, e.g. changing the subject can **reduce** shame about sadness. These defensive avoidance behaviors are not signs of observable inhibition, and thus are not coded. (Defenses can be scored on Perry's DMRS—Defense Mechanism Rating Scale). Keep in mind the following:

- The healthiest individuals score low on inhibitory feeling because they are comfortable with their feelings, and at ease. They also have low defensiveness.
- The most defended patients can seem low on the inhibitory feeling scale because their defenses are effective in blocking 'anxieties,' but if you look for vigilance, tension, or bodily rigidity you will find some. The rating may not be high, but it will not be in the lowest range (1-10), which will only be scored by individuals who are comfortable or at ease with themselves.
- When defenses break down or are only partially effective, inhibitory feelings become more observable and easier to rate.
- Remember that there are **appropriate** versions of anxiety, shame (or remorse), or pain that are **healthy**. For example, **appropriate** shame/remorse is adaptive when it promotes resolution or growth, and it is often accompanied by adaptive grief. Adaptive inhibition is not rated.

BRIEF OVERVIEW OF LEVELS OF INHIBITORY AFFECTS: VERBAL OR NONVERBAL SIGNS OF ANXIETY, GUILT, SHAME, PAIN, ETC.

**81-100--Extreme inhibitory affect:** e.g., extreme shakiness, hesitancy, vigilance, trembling, anxiety or shame. Extreme uneasiness.

**61-80--High inhibitory affect:** e.g., high levels of shakiness, hesitancy, vigilance, trembling, anxiety or shame. Great uneasiness.

**41-60--Moderate inhibitory affect:** e.g., moderate shakiness, hesitancy, vigilance, trembling, anxiety or shame. Moderate uneasiness.

**21-40--Low inhibitory affect:** e.g., low shakiness, hesitancy, vigilance, trembling, anxiety or shame. Low level of uneasiness.

**1-20--Little or no inhibitory affect.** Little or no shakiness, guardedness, hesitancy, vigilance, trembling, anxiety, etc. Comfortable, at ease.

**91-100 Extreme inhibitory affect.** Flooded with anxiety, guilt, shame, or pain as shown by verbal report and/or by signs such as extreme shakiness, hesitation, sighing, or vigilance. Body movement and muscles are extremely tight, tense and rigid. Tone of voice is extremely hesitant, trembling or inaudible. Extreme uneasiness. (Over 90% inhibition.)

**81-90 Very high inhibitory affect.** Very high levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as very great shakiness, hesitation, sighing, or vigilance. Body movement and muscles are greatly tight, tense and rigid. Tone of voice is greatly hesitant, trembling or inaudible. Very high uneasiness. (81-90% inhibition.)

**71-80 High Inhibitory Affect.** High levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as great shakiness, hesitation, sighing or vigilance. Body movement and muscles are highly tight, tense and rigid. Tone of voice is greatly hesitant, trembling or inaudible. High level of uneasiness. (71-71-80% inhibition.)

**61-70 High-moderate inhibitory affect.** More than moderate levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as above moderate levels of shakiness, hesitation, sighing or vigilance. Body movement and muscles are more than moderately tight, tense and rigid. Tone of voice is more than moderately hesitant, trembling or inaudible. Above moderate level of uneasiness. (61-70% inhibition.)

**51-60 Moderate inhibitory affect.** Moderate levels of anxiety, guilt, shame or pain, shown by verbal report and/or by signs such as moderate shakiness, hesitation, sighing, tension or vigilance. Body movement and muscles are moderately tight, tense and rigid. Tone of voice is moderately hesitant, trembling or inaudible. Moderate uneasiness. (51-60% inhibition.)

**41-50 Low-moderate inhibitory affect.** Low-moderate levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as shakiness, hesitation, shifting, sighing, tension or vigilance. Body movement and muscles are less than moderately tight, tense and rigid. Tone of voice is less than moderately hesitant, trembling or somewhat difficult to hear. Less than moderate uneasiness. (41-50% inhibition.)

**31-40 Low inhibitory affect.** Low levels of anxiety, guilt, shame or pain as shown by verbal report and/or by signs such as shakiness, hesitation, shifting, sighing, vigilance. Body movement and muscles show low levels of tightness, tension or rigidity. Tone of voice shows low level of hesitance, trembling or somewhat difficult to hear. Low level of uneasiness. (31-40% inhibition.)

**21-30 Little inhibitory affect.** Little anxiety, guilt, shame or pain as shown by verbal report and/or by such signs as shakiness, hesitation, shifting, sighing, vigilance. Body movement and muscles show little tightness, tension or rigidity. Tone of voice has little hesitance, trembling, and is audible. A little uneasiness. (21-30% inhibition.)

**11-20 Very little inhibitory affect.** Very little anxiety, guilt, shame or pain as shown by verbal report and/or by such signs as shakiness, hesitation, shifting, sighing, or vigilance. Body movement and muscles show very little tightness, tension or rigidity. Tone of voice has very little hesitance, trembling, and is audible. Very little uneasiness. (11-20% inhibition.)

**1-10 No Inhibitory Affect.** No (or almost no) anxiety, guilt, shame or pain as shown by verbal report and/or by signs such as absence of shakiness, hesitation, shifting, sighing, or vigilance. Body movement and muscles are relaxed and movement is smooth and coordinated. Behavior and vocal tone are calm, spontaneous, natural, and very audible. Inhibitory thoughts or feelings, if present, are there to help, guide, direct and protect. No muscle tension is evident. Comfortable and at ease. (10% inhibition or less.)

## NEW EMOTIONAL LEARNING:

### Level of Adaptive Expression of Thoughts, Feelings, Wishes, Needs 16APR09

STDP : Affect Expression: Ability to adaptively express thoughts, feelings, wishes, needs CBT: Ability to adaptively express thoughts, wishes, needs. DBT: Implementation of skills training. Adaptive decision-making/judgment vs. crisis generating behaviors. Accuracy of communication of emotions and competencies. Decreasing mood dependency of behavior.

#### MAIN COMPONENTS:

1. Appropriate, adaptive interpersonal, **face-to-face** expression (spirited but well-controlled and well-integrated) of thoughts and feelings. As of Aug 2008, if affect is expressed directly in the real relationship with the therapist, this should be noted as 'in session' expression.
2. Degree of relief/satisfaction versus discomfort in action or expression.

NOTE: **Face-to-face** means **in-person, real-life interactions outside of therapy** (i.e., how spontaneous/ authentic is the patient able to be with others?) This is adaptive, **not** regressive or immature expressions. **Valid exceptions** to **face-to-face** expression: reports of adaptive crying when alone (if not to avoid doing so with others); adaptive masturbatory behavior; or adaptive self care or self-talk when alone.

#### BRIEF OVERVIEW OF LEVELS OF NEW EMOTIONAL LEARNING OF ADAPTIVE EXPRESSION

**81-100 Excellent expression** of thoughts/feelings; sense of completeness, balance, and excellent results. Great relief and satisfaction experienced.

**61-80 - Good expression** of thoughts/feelings; slight holding back. Not all expressed, but good sense of relief in speaking up. Good satisfaction.

**41-60 - Moderate expression** of thoughts or feelings; moderate holding back, but moderate effectiveness. Moderate relief. Moderate satisfaction.

**21-40 - Beginning attempt to express** thoughts or feelings. Much holding back. A little relief in expression. A little satisfaction.

**1-20 - No expression** of adaptive thoughts or feelings. Total holding back. No relief. No satisfaction. High end of this rating level: can begin to imagine expressing adaptive thoughts or feelings, wants and needs, but is as yet unable put it into action.

- 91-100 Excellent, full, free and unashamed expression of thoughts or feelings, wants/ needs.** Excellent, well-modulated and well-articulated communication. Acknowledges other emotions that come up and can integrate them. A sense of full completeness and close interpersonal involvement that invites and encourages connection – but can tolerate conflict when unavoidable. Great relief and satisfaction. No discomfort in expression.
- 81-90 Very good expression of thoughts or feelings.** Very good communication of needs in a clear, and direct/effective way, and very good but not full integration of other adaptive thoughts or feelings with most people, but not all. Very well-modulated expression with very much relief and very little if any discomfort.
- 71-80 Good expression of thoughts or feelings.** Good, clear and direct expression with some integration of other adaptive thoughts or feelings (e.g., anger with compassion). Well-modulated expression with much relief and some discomfort.
- 61-70 High moderate expression of thoughts or feelings.** Much clear expression with beginning attempts to integrate other thoughts or feelings or a little indirect but gets the message across. Partially modulated bursts of adaptive feeling. More relief than discomfort.
- 51-60 Moderate expression of thoughts or feelings.** Some clarity and elaboration. Expression may be toned down/devalued, or indirect/unclear/ambiguous. Thoughts or feelings not yet integrated (black or white presentation). Slightly modulated. Moderate relief and moderate discomfort in expression.
- 41-50 Low-moderate expression of feelings or needs.** Very little elaboration and expression may be quickly toned down or devalued. Unintegrated and poorly modulated. Beginning awareness of impact on others. More discomfort than relief.
- 31-40 Minimal expression of thoughts or feelings.** Briefly expresses thoughts or feelings, but may do so inappropriately, with difficulty or without elaboration, or indirect/unclear/ambiguous. Either very poor modulation (mostly inhibited/holding back)—or too little inhibition with inappropriate acting out with much discomfort in expression.
- 21-30 Beginning attempt to express thoughts or feelings, to others.** Expresses some thoughts or feelings maladaptively or with great difficulty, e.g. irritation, frustrated anger or anxious assertion or closeness or quickly overwhelmed by inhibitory thoughts or feelings that block expression. Inappropriate expression; e. g. childlike, immature. Very poorly integrated with other thoughts or feelings and very poorly modulated. Very much discomfort in expression.
- 11-20 No interpersonal expression of thought or thoughts or feelings, but can imagine expressing them.** High end: Can imagine doing so, but has not actually done it yet. Low end: Can barely imagine expressing thoughts or feelings or imagines doing so inappropriately or losing control. Some regressive or inappropriate behaviors instead of appropriate expression.
- 1-10 No adaptive expression of thoughts or feelings, and cannot imagine expressing feelings appropriately.** High end: Aware of thoughts or feelings, but can't imagine expressing them. Low end: No idea of how to express own thoughts or feelings/needs. Great discomfort/tension/turmoil or numbness. Much regressive acting out behavior to replace appropriate expression

**LEVEL OF SENSE OF SELF 16APR09**  
STDP: Restructuring of the Sense of Self  
CBT: Improvement in self-esteem and positive self talk  
DBT: Degree of self-validation vs self-invalidation.

**MAIN COMPONENTS:** The patient's inner experience or verbal report of adaptive self image, in terms of the following:

1. Degree of experience of self compassion, self care, or value as a human being.
2. Degree of adaptive pride in positive qualities (not defensive pridefulness or grandiosity): e.g., self worth, self esteem, competence, etc.
3. Degree of ability to compassionately acknowledge and accept one's limitations or realistic negative qualities of the self.

NOTE: Both grandiosity and devaluation of self should be considered maladaptive.

**BRIEF OVERVIEW OF LEVELS OF SENSE OF SELF**

**81-100 - Highly adaptive** sense of self; compassionate and accepting of strengths and vulnerabilities.  
**61-80 - Very adaptive** sense of self; much compassion and acceptance, but some self-blame or shame present.  
**41-60 - Moderately adaptive/maladaptive** aspects of self-image in approximately equal amounts.  
**21-40 - Very maladaptive** sense of self, but a little compassion, and a little ability for acceptance.  
**1-20 - Highly maladaptive** sense of self; little or no compassion, awareness, or self acceptance—or excessive grandiosity

- 91-100 Highly adaptive sense of self.** Great but healthy pride in own strengths (not grandiose), and highly affirming of own wants and needs, but not demanding. Very realistic but highly compassionate about own weaknesses. Great sense of self-compassion and self-acceptance, with almost no self-blame or shame.
- 81-90 Mostly adaptive sense of self.** Very much pride in own strengths and very much affirming of own wants and needs. Very much ability to acknowledge and accept limitations. Very much compassion and self-acceptance, but a little self-blame or shame.
- 71-80 Very adaptive sense of self.** Much pride in own strengths, and quite affirming of own wants and needs in relation to others. Much ability to acknowledge and accept limitations. Much compassion and self-acceptance, but some self-blame or shame.
- 61-70 Somewhat adaptive sense of self.** Some pride in own strengths, and some affirming of own wants and needs. Some ability to acknowledge and accept limitations. Some compassion and self acceptance, but moderate self-blame or shame present.
- 51-60 Mixed adaptive/maladaptive view of self.** Slightly more adaptive than maladaptive view of self. Slightly more pride than shame in self. Compassion and self-acceptance slightly greater than devaluation or grandiosity. Only moderately affirming of own wants and needs. Only a little more compassion and self-acceptance than self-blame or shame.
- 41-50 Mixed maladaptive/adaptive view of self.** Slightly more maladaptive than adaptive view of self. Slightly more shame than pride in self. Devaluation or grandiosity is slightly stronger than self-compassion or acceptance of limitations. Only moderately affirming of own wants and needs. Slightly more self-blame and shame than compassion for self.
- 31-40 Somewhat maladaptive sense of self.** Some shame in self. Minimal pride in own strengths. Somewhat affirming of own wants and needs in relation to others. Somewhat able to acknowledge and accept limitations. Some compassion and self-acceptance of self regarding limitations, but more self-blame or shame.
- 21-30 Very maladaptive sense of self.** Much shame in self. Little pride/some grandiosity. Almost no affirming of wants and needs. Minimal ability to acknowledge and accept limitations and minimal ability to control impulses. Minimal compassion and self acceptance of self regarding limitations. Much self-blame or shame.
- 11-20 Mostly maladaptive sense of self.** Very much shame and very little pride/or much grandiosity. Devaluation of self or wants and needs. Very little ability to acknowledge and accept limitations. Very little ability to control impulses. Very little compassion and self-acceptance, but very much and very destructive self-blame or shame.
- 1-10 Highly maladaptive sense of self.** Extremely maladaptive view of self, with little or no pride/or extreme grandiosity. Denying or ignoring wants and needs. Little or no ability to acknowledge and accept limitations or control impulses. Almost no compassion or self-acceptance, but extremely destructive self-blame or shame.

## LEVELS OF SENSE OF OTHERS 8/20/08

STDP: Restructuring Sense of Others

CBT: Improvement in relationships

DBT: Improvement in relationships. Dialectical thinking about others. Adaptive dependence on others.

**MAIN COMPONENTS:** The patient's report of adaptive and realistic images of other people, in terms of:

1. Degree patient can acknowledge or respond to others' positive qualities.
2. Degree patient can acknowledge and set limits around destructive or (realistic) negative qualities in others.

NOTE: Over-idealization, naïveté or tolerance of abuse as well as undeserved devaluation of others is considered maladaptive.

### BRIEF OVERVIEW OF LEVELS OF SENSE OF OTHERS

**81-100 - Highly adaptive** sense of others. Very much compassion/acceptance/trust in others; little or no idealization or devaluation.  
**61-80 - Very adaptive** sense of others. Much compassion/acceptance/trust, but some devaluation or idealization.  
**41-60 - Moderately adaptive** as well as maladaptive aspects; moderate compassion/acceptance/trust, moderate devaluation/idealization.  
**21-40 - Very maladaptive** sense of others, but some compassion, empathy or ability for acceptance; much devaluation or idealization.  
**1-20 - Highly maladaptive** sense of others; Little or no compassion, empathy or acceptance. Very much devaluation, idealization or splitting.

- 91-100 Highly adaptive sense of others.** Highly compassionate/accepting/trusting but realistic about others' weaknesses, admiring of others' strengths, and affirming of others needs and wants. No idealization/devaluation or naïveté. Great ability to tolerate and work with conflict or set limits. Excellent ability to integrate positive and negative qualities of others.
- 81-90 Very adaptive sense of others.** Very much compassion/acceptance/trust, but occasionally a little devaluation or idealization. Almost no tendency toward naïve/compliant or suspicious/ projecting. Very good ability to tolerate and work with conflict or set limits with others. Very good ability to integrate positive and negative qualities of others.
- 71-80 Moderately adaptive sense of others.** Much compassion/acceptance/trust of others, but occasionally a little devaluation or idealization. Only a little naïve/compliant or suspicious/ distrustful/ projecting. Good ability to tolerate and work with conflict, limit-setting or negative qualities in others. Good ability to integrate positive and negative qualities of others.
- 61-70 Minimally adaptive view of others.** Somewhat more compassion/ acceptance/trust, than devaluation or idealization. Minimally naïve/compliant or suspicious/ distrustful/ projecting. Above moderate ability to tolerate and work with conflict, limit-setting or negative qualities in others. Above moderate ability to integrate positive and negative qualities of others.
- 51-60 Mixed adaptive/maladaptive view of others.** Compassion or acceptance of others is a little stronger than devaluation or idealization. Somewhat naïve/compliant or suspicious/ distrustful/ projecting. Moderate ability to integrate positive and negative qualities of others. Moderate ability to tolerate and work with conflict and set-limits.
- 41-50 Mixed maladaptive/adaptive view of others.** Devaluation or idealization is a little stronger than compassion or acceptance. Somewhat naïve/compliant or suspicious/ distrustful/ projecting. Somewhat below average ability to tolerate or work with conflict, or integrate positive and negative qualities of others.
- 31-40 Somewhat maladaptive view of others.** Somewhat more devaluation or idealization than compassion or acceptance. A slight tendency toward splitting others into all good or all bad. Somewhat naïve/compliant or suspicious/ distrustful/ projecting. Only fair ability to tolerate and work with conflict or set limits - nor to integrate positive and negative qualities of others.
- 21-30 Very maladaptive sense of others.** Much devaluation/idealization and little compassion/acceptance/tru. Others split to moderate degree into all good/all bad. Very naïve/compliant or suspicious/distrustful/ projecting. Poor ability to tolerate and work with conflict or set limits – nor to integrate positive and negative qualities of others.
- 11-20 Mostly maladaptive sense of others.** Very much devaluation or idealization, and very little compassion/acceptance/trust. Others split to large degree all good/all bad. Highly naïve/compliant or suspicious/distrustful/projecting. Very poor ability to tolerate or work with conflict or set limits – nor to integrate positive and negative qualities of others.
- 1-10 Extremely maladaptive sense of others.** Extremely negative and devaluing, or over-idealized. Almost no compassion, acceptance or trust. Others split almost totally into all good/all bad. Extreme naïveté, projection, paranoia/distrust. Little or no ability to tolerate and work with conflict or set limits – nor to integrate positive and negative qualities

